# phoenix rising

**The Outspoken Voice of Psychiatric Inmates**

**Winter 1981 Vol.1 No.4** **$1.50**

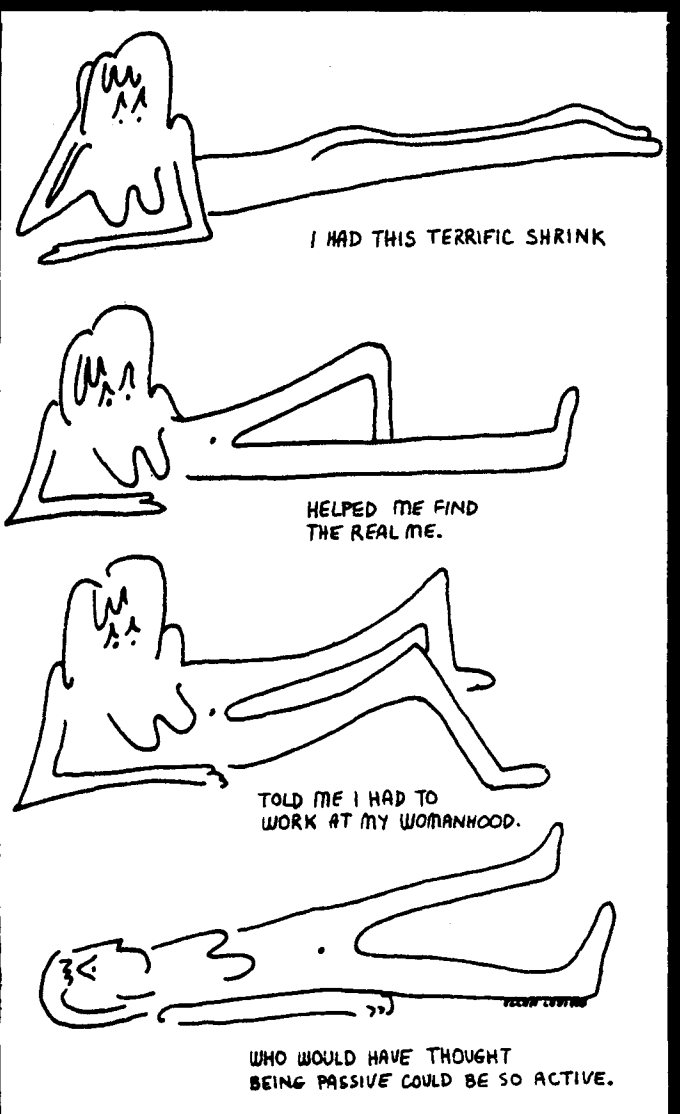
# WOMEN AND PSYCHIATRY

## Interview with Dr. Chesler

## Forced sterilization

## Lithium- "wonder drug"

## Aldo inquest and after



# PHOENIX RISING

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*If you live outside Toronto and know of a bookstore that might be interested in carrying us, show them a copy of our magazine and write to us. We'll try our best to see that PHOENIX RISING is sold in your city.*

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The Outspoken Voice of Psychiatric Inmates

HAPPY BIRTHDAY, PHOENIX!

Our Women's Issue marks the end of our first year as a magazine--a far cry from the "newsletter we had originally intended to start. A one-time grant of $5,600 from Ontario PLURA (an inter-church agency), along with a very generous donation from William Harmer of Ottawa, and subscriptions and donations from readers, have helped us produce a publication we're proud of.

Through the volunteer labour of our collective members, the work of one part-time editor, and a sympathetic printer with reasonable prices, we've managed to survive--and grow. Thanks to a Canada Community Development Project grant, our editor will be working full-time in 1981, and an advertising and public relations person will soon be joining our staff. They and the PHOENIX RISING collective will be working hard to produce a magazine as good as last year's, but with expanded circulation across Canada and more out-of-Ontario news.

In 1981, the International Year of Disabled Persons, we hope to cover a greater variety of "mental health" and human rights issues. We'll be counting on you to help us keep on top of what's going on out there. Your letters, criticisms, poems and articles will help us ensure that our magazine continues to be a forum for public discussion, education and social support, and--most important--a major organizing tool for psychiatric inmates and former psychiatric inmates.

A HEALTHY AND HAPPY NEW YEAR!

*Cathy McPherson, Carla McKague, Don Weitz, Jo-anne Yale, Mike Yale, and Bill Lewis.*

phoenix rising
The Outspoken Voice of Psychiatric Inmates

*Through the fire*

PHOENIX RISING is published quarterly or more often by: ON OUR OWN, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9. Telephone: (416)-362-3193.

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Cathy McPherson

EDITORIAL COLLECTIVE

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Carla McKague
Don Weitz
Jo-anne Yale
Mike Yale
Bill Lewis

The opinions of the editorial collective are expressed in the editorials and unsigned articles. Other articles, columns and letters to the editor express the views of the writer.



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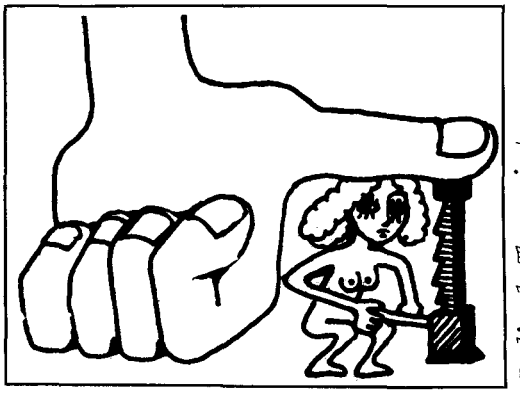
# Out from under

Toward the end of his life, Sigmund Freud admitted ruefully that he had never been able to figure out the answer to the question, "What do women want?" One reason he had never managed to solve this problem was that he listened very selectively to what his female clients had to say. He refused, for example, to believe the many stories women told him of being sexually molested by their fathers or other close relatives. He had a fixed picture of women, and simply discarded any information that did not fit his picture.



*Radical Therapist*

Many years later most psychiatrists, including women psychiatrists, still suffer from this peculiar inability to hear what women say to them. For the most part, they have a stereotypical image of what a "healthy" woman is: one who is passive and accepting, who dresses in a feminine manner, who is appropriately helpless when faced with any kind of serious situation, and who sees the goal of her life as being supported by the "right" man and devoting herself to raising sons who will be world-beaters and daughters who will latch onto another "right" man and repeat the cycle.

*(continued over)*

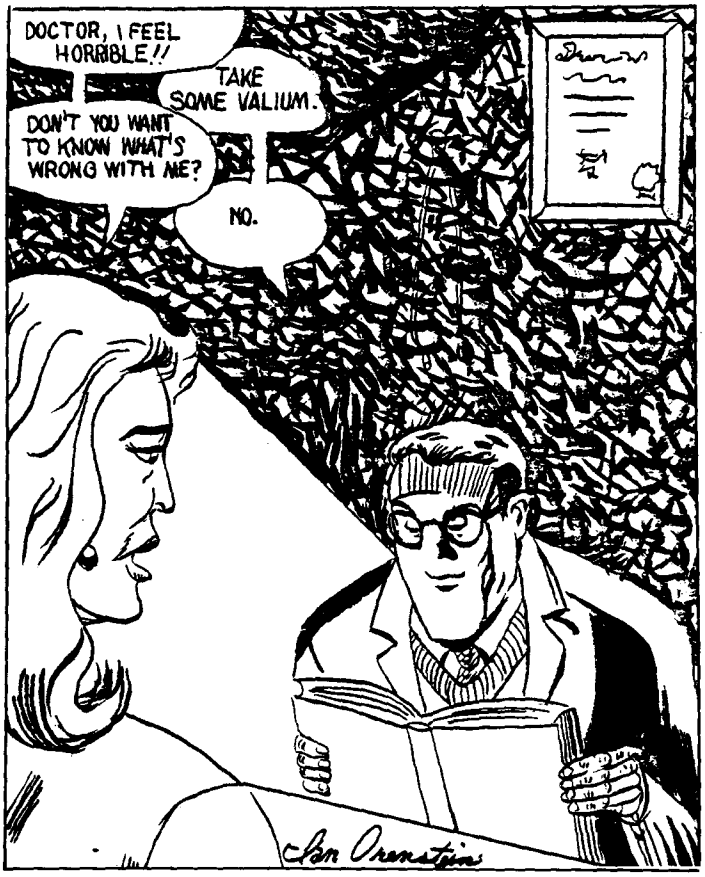
# contents



*Cover drawing from* Pulling Our Own Strings.

CONTRIBUTORS: *Arrow, David Baker, Harry Beatty, Leonard Frank, Philip Giglio, Tony Myers, Ian Orenstein, Alison Sawyer. Special thanks for assistance to Bonnie Armstrong, Anne Coy, Reg Foster, Wilf Olin and Benjy Wolfe.*

The evidence that this is the case is overwhelming. Study after study has shown how psychiatrists, in the main, see their task with an unhappy woman as adjusting her to her




proper role in our society. If a woman has a lousy marriage, she is encouraged--not to leave her husband, but to learn to tolerate his callousness, brutality or drunkenness. If she longs for some kind of independent achievement, she is persuaded that this desire is unbecoming and unrealistic. If she prefers to wear slacks, she may well be labelled a lesbian.

Phyllis Chesler reports a striking example of this kind of attitude in her book Women and Madness. A number of women who had been hospitalized as "schizophrenic" were eventually released. A researcher did a follow-up study to see whether there were any differences between those women who were later re-admitted and those who were not. The groups showed almost exactly the same incidence of most "symptoms"--crying, lack of caring for themselves, and so on. The one big difference was that the women who were re-admitted (usually by their husbands) were the ones who refused to do the housework.

Women are prescribed far more tranquillizers than men. Faced with the serious frustrations in most women's lives, psychiatrists refuse to deal with the very real problems, and instead blame it all on "nerves" and write prescriptions for Valium. Women get shock treatment almost twice as often as men. One has to wonder if this is some sort of sick substitution for the no-longer-acceptable custom of beating up a wife or daughter who doesn't do as she's told. Many women can tell stories of being released from a psychiatric ward only when they've succumbed to the pressure to put on a skirt and some lipstick and have their hair done.

There is some hope for women who have difficulties and seek professional help. A few therapists--particularly women therapists--do not share the prevalent attitude, and will help women to achieve what *they* see as their goals. Places such as the Women's Counselling, Referral and Education Centre in Toronto (see Profiles section) have been established to help women find this sort of help. But there has been little or no change in *institutional* psychiatry; the woman entering a psychiatric ward or hospital is faced with the same old stereotypes and expectations.

This issue of PHOENIX RISING is dedicated to all those women who have been damaged by a sexist and paternalistic system, and to the handful of "mental health" professionals who want to help women escape from the traps and dead-ends of that system.

*NEW STORE HOURS*

*As of January 1, 1981*

*THE MAD MARKET has been trying out new store hours. Please note the changes.*

*OPEN: Tuesday to Saturday, 9:30 a.m. to 6:00 p.m.*

*CLOSED: Sunday and Monday*

Following up on our Shock Issue of PHOENIX RISING, ON OUR OWN is holding a series of workshops on shock therapy during January and February--every Wednesday from 7:30 to 9:30 in the Main Hall at St. Christopher House, 761 Queen St. W. All present and former psychiatric inmates are invited to attend and take part in the discussion. For more information, call Don at 362-3193.

# WRITE ON

A while ago I received your PHOENIX PHARMACY newsletter in the mail. *(NOTE: Copies of the section on Thorazine were mailed to all members of* ON OUR OWN.*)*

I don't usually write (I'm very timid), but since this touches my own experience I thought I'd try. From the newsletter I get the impression that most of your group is anti-drug, especially anti-psychiatric drug. I'd like to present a different point of view.

## *"What is the reason for this staunch anti-drug philosophy?"*

(1) All drugs, no matter what they are, or for what condition they are given, have an element of risk involved with their use. Aspirin can cause stomach ulcers, penicillin can cause serious allergic reactions, baking soda can cause alkalosis (blood is too alkaline). Yet this does not call for abolishing the use of the drug, if to be left untreated makes you worse off than if you had the drug. Phenothiazines are no exceptions to this rule.

(2) According to what we have been told by professors, phenothiazines result in a significant reduction of recidivism (going back to hospitals) for schizophrenic patients, and the length of time from discharge to re-admission is increased. I have spoken to someone who said she really benefitted from Stelazine. I have taken it in low doses (4 mg/day) and it definitely helped me.

(3) Re the boycott: Why boycott only SmithKline? They may make the "brand-name" drugs, but other companies produce the same drugs under their generic names. Why not find them and boycott them also?

(4) Is the goal to boycott the use of such drugs as the phenothiazines altogether, or is it rather to promote the introduction of more effective, more specific drugs with fewer deleterious side effects? I would like to believe the goal is the latter.

(5) What is the reason for this staunch anti-drug philosophy? Is it the fear of being controlled and aided by a chemical? Does this question the nature of "mind" and of "will"?

(6) Re references: I haven't looked in the CPS, but my Remington's Pharmaceutical Sciences (16th ed., Mack Publishing Co., Easton, Pa., 1980), also a reference used by pharmacists and doctors, has "Compazine *(Smith, Kline & French)*" given under the heading *Prochlorperazine Edisylate* on page 750. So certainly the fact that SKF manufactures Compazine isn't being hidden in all the reference books.

I suppose you can guess that I'm a pharmacy student, and so, understandably, I have a pro-drug bias. But I am also a former psychiatric patient who has an emotional disturbance. I am anxious, agitated, and frequently aggressive, if left untreated. I was given the Stelazine by a psychiatrist. I took it for six months, but stopped because (a) it wasn't 100% effective (it didn't control my tachycardia), and (b) I became less creative and wrote fewer songs.

After about a year and a half, I started experiencing relapses. I visited a doctor who treated me with Inderal, for cardiovascular complaints. Surprisingly, my emotional disturbance also vanished. Please don't say the illness was physical and not psychiatric. It manifested itself as psychiatric disturbance--anxiety and aggression. These latter were successfully treated with a drug. I have no serious side effects (just some fatigue due in part to a minor heart problem). I have been taking it for over a year (dose 80 mg b.i.d.).

All I want to say is, don't knock drug therapy for psychiatric conditions altogether. Some people with some psychiatric conditions will benefit from some psychiatric drugs. I know I would not have been able to come here or study pharmacy without that drug.

*--Esther Lucy Rodriguez, Saskatoon, Saskatchewan*

*You have raised some very important questions, and we welcome the chance to clarify our position.*

*(1) What you say about all drugs having side effects is true. However, psychiatric*

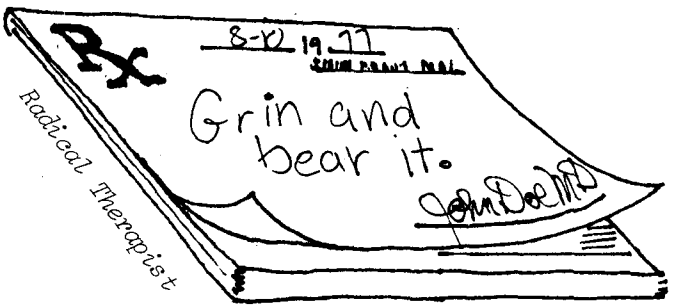
drugs as a class have much more frequent and much more severe side effects than most others. As well, they are frequently given to people who are not told about these effects, and who are given no choice as to whether to take them. The effects are inflicted on people who are not allowed to make a reasoned decision about whether they are prepared to take the risks involved.

# "They strike only one manufacturer at a time"

(2) Why boycott only SmithKline? As a matter of practical necessity. We couldn't boycott all the drugs made by all drug companies and deal with our physical illnesses at the same time. There's a parallel with what happens when the United Auto Workers want a pay raise; they strike only one manufacturer at a time. They make their point without inflicting undue hardship on their members, and the other companies fall into line because they know they're next if they don't. SmithKline is an example, and we picked them as the example because they were the originators of the phenothiazines.

(3) Our goal is not to wipe out psychiatric drugs completely, although it might well be that in the case of the phenothiazines. We are not totally anti-drug. What we are against is: drugs used on people against their will, drugs used without explanations of their very real dangers, drugs used in dangerous amounts, drugs used to cover up problems so that doctors won't have to take the time to solve them. If drugs must be used in a crisis, it's good medicine to use the smallest possible amount for the shortest possible time. That is, unfortunately, not what happens. And that is certainly not how the drug companies, including SKF, advise doctors to use their products.

Your own experience, as you relate it in your letter, illustrates our point. It would seem that your cardiovascular problems resulted in behaviour difficulties--anxiety and aggression. The answer was to treat the cardiovascular problem, not to consider the other symptoms as a psychiatric illness. Similarly, depression caused by severe personal difficulties is best handled by solving those difficulties or coming to terms with them, not by masking them with antidepressants. Emotional problems have causes, and the irresponsible use of potent drugs doesn't get at the causes. Even the responsible use of these drugs provides only temporary relief; permanent help can only come from doctors taking the time and effort to find out why we are anxious, aggressive, depressed, or whatever, and helping us deal with those causes. The general acceptance and availability of these drugs makes it easy for them to abdicate that responsibility.

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I would like to compliment the staff of PHOENIX RISING for successfully producing an interesting thought-provoking publication. You have a unique and powerful vehicle with which to promote the kind of dialogue and debate necessary for the humane and effective resolution of problems of concern to patients and mental health personnel alike.

As a social worker engaged in community

education work I appreciate the opportunity to hear and perhaps better understand the feelings and ideas of patients and ex-patients. With your help I can do my job better.

I wish you the best with your ongoing work.

--*Michael J. Poulin, Community Mental Health Worker, Canadian Mental Health Association, Ottawa, Ontario*

★ ★ ★ ★ ★ ★

Please send me information about your group. I have just returned to work after a couple of pretty horrible years, a lot of drugs, hospitals, etc. Trying to function again is so hard and so scary that I often feel I can't go on, and there's *no* support in this city except one emergency service, which is Hospital again and I've had bad experiences there. The few friends who are still around are worn out from dealing with me and my mess and they want so badly to believe I'm okay now that I can't let them see any different. The pretending gets awful sometimes. I need to know that others have made it past these nightmares. Please write.

--*Name withheld, Hamilton, Ontario*

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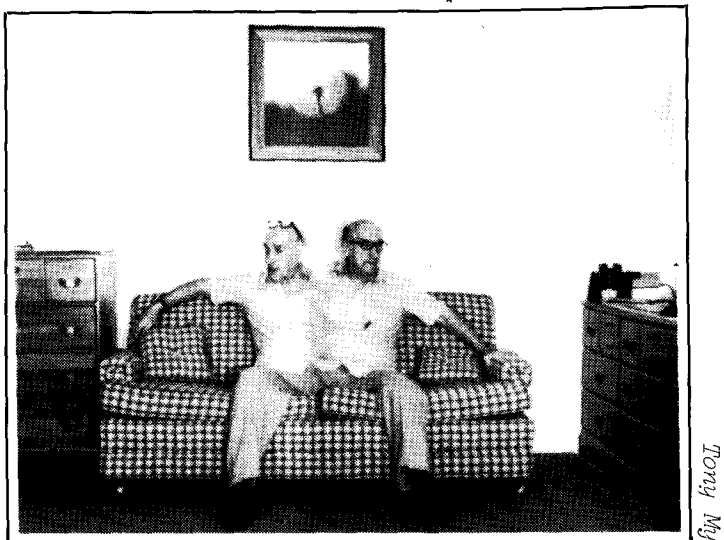
As a new subscriber to your magazine, I am appalled at your list of "Canadian Shock Docs" in the Fall 1980 vol. 1, no. 3.



*"The doctors say I have a split personality."*

Tony Myers

One of those listed, a Dr. S.K. Littman of the Clarke Institute, may very well be in a position to authorize ECT treatment, but I most sincerely feel, having known Dr. Littman as a very caring, sensitive and most knowledgeable health care professional with regard to one of my family, that he would *not* order ECT treatment without the most careful case study possible.

With regard to ECT treatment, it would

*continued on page 43*

# ON OUR OWN

# Aldo: the inquest and after

The last issue of PHOENIX RISING told you about Aldo Alviani, a 19-year-old Toronto man who died after being given massive amounts of drugs at the Queen Street Mental Health Centre.

*Aldo Alviani*

When news of Aldo's death and an apparent cover-up of that death broke in September, ON OUR OWN held a protest march and demonstration. Public pressure from many sources finally forced an inquest in November.

ON OUR OWN joined together with seven other organizations in an attempt to get standing at the inquest to present a number of concerns we feared would not be raised otherwise. The other groups involved were:

--HouseLink Community Homes (an organization which helps ex-inmates set up cooperative housing, and is largely ex-inmate-controlled);

--Friends and Advocates (which provides so-

*Henry Durost, Medical Director, Queen Street*

Re: action

cial support for people leaving psychiatric institutions, and also has a large ex-inmate membership);
--Patients' Rights Association (set up by people who have suffered injustices in all areas of medical practice);
--Canadian Mental Health Association--both Ontario Division and Metropolitan Toronto Branch (a voluntary association of people concerned with the quality of psychiatric care in Canada);
--Ontario Association for the Mentally Retarded (a similar group with special concerns about the overdrugging of people with developmental handicaps); and
--Medical Reform Group of Ontario, Toronto Chapter (a group of doctors and medical students dedicated to providing the best quality of health care to all people).

**Uriel Priwes**

We were legally represented by the Advocacy Resource Centre for the Handicapped (see PHOENIX RISING, *vol. 1, no. 1*), which put one staff member at our service full-time for the duration of the inquest, and whose Executive Director, David Baker, also gave a great deal of time to our application for standing.

Our effort to get standing failed; the Coroner, Dr. Peter King, ruled that we did not have a "substantial and direct interest" in the findings of the inquest. We sought review of his finding in court, but in spite of a very able and persuasive argument by ARCH the court upheld Dr. King.

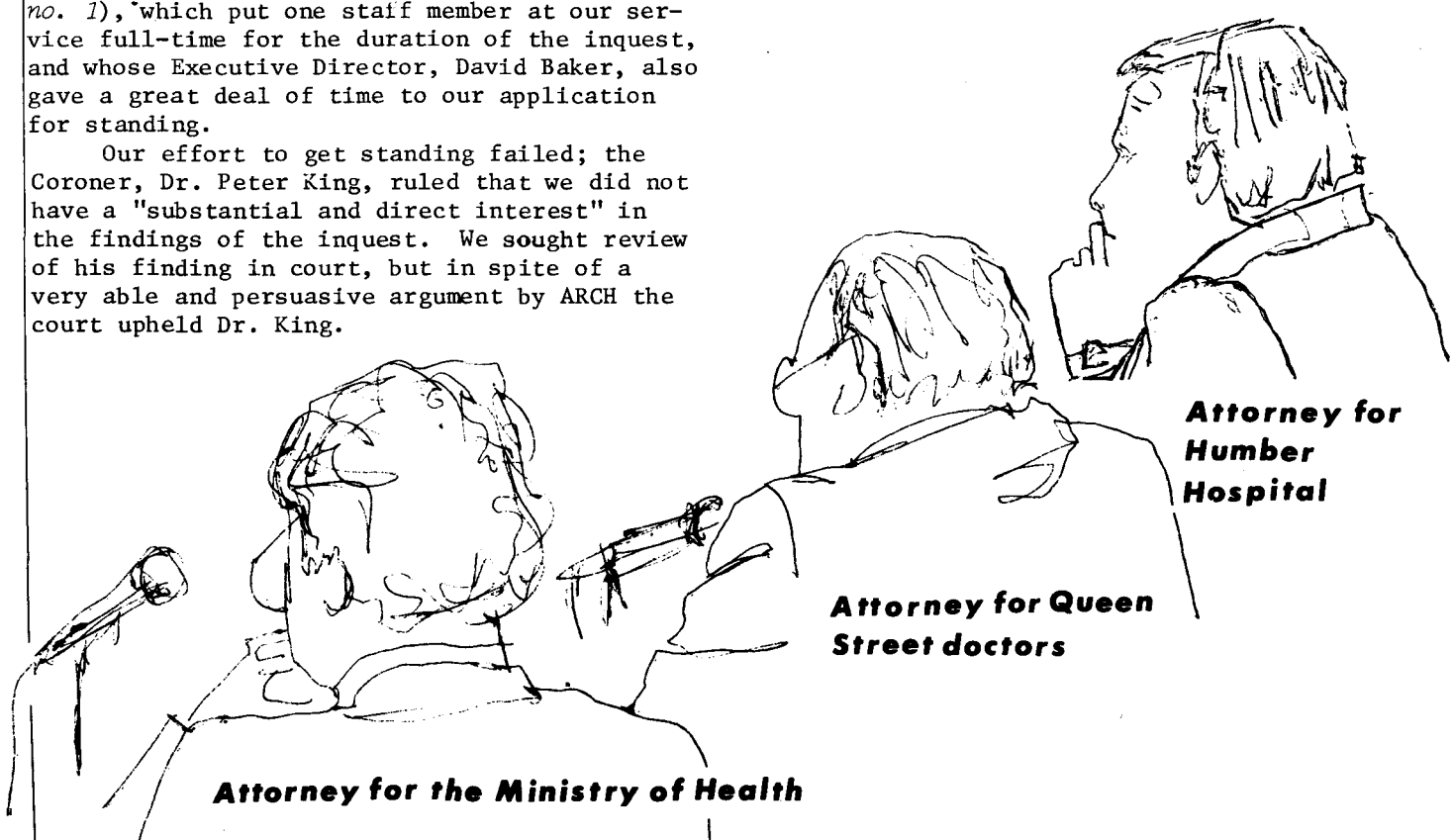
This was especially unfortunate since Aldo's family chose *not* to take part in the inquest, and there was therefore no one to represent the interests of inmates.

As a kind of consolation prize, Dr. King and Mr. Uriel Priwes (the Crown Attorney) indicated that they would be happy to hear our suggestions about what witnesses should be called and what questions should be asked. Carla McKague (our ARCH representative) and Reg Foster (our elected spokesperson) devoted con-

## Therapeutic misadventure

siderable time and effort, with the help of other members of the coalition, to drawing up suggestions and presenting them to Mr. Priwes and Dr. King. Unfortunately, almost none of these suggestions was acted upon. Consequently the inquest jury did not hear much of the information we wanted to get before them about just what goes on in Ontario's psychiatric institutions, and how that compares with good medical practice.

On the basis of what they *did* hear, the jury brought in a finding of death by "therapeutic misadventure". What that translates into is that the drugs given to Aldo (see box) caused his death, but it was a regrettable accident, and no one was really to blame. We can't fault the jury; given what they'd heard



**Attorney for Humber Hospital**

**Attorney for Queen Street doctors**

**Attorney for the Ministry of Health**

**THE DRUGS ALDO ALVIANI RECEIVED**

(Generic names are used. Haloperidol is also called Haldol; chlorpromazine is Thorazine; methotrimeprazine is Nozinan; diazepam is Valium.)

| | | |
|---|---|---|
| **Saturday June 21, 1980** | | |
| 11:20 p.m. | 75 mg. | chlorpromazine |
| **Sunday June 22, 1980** | | |
| 3:20 a.m. | 10 mg. | haloperidol |
| 6:30 a.m. | 15 mg. | haloperidol |
| 7:00 a.m. | 15 mg. | haloperidol |
| 7:30 a.m. | 15 mg. | haloperidol |
| 8:00 a.m. | 15 mg. | haloperidol |
| 8:30 a.m. | 15 mg. | haloperidol |
| 9:00 a.m. | 15 mg. | haloperidol |
| 9:30 a.m. | 15 mg. | haloperidol |
| 10:00 a.m. | 15 mg. | haloperidol |
| 1:00 p.m. | 40 mg. | haloperidol |
| 1:30 p.m. | 15 mg. | haloperidol |
| 5:30 p.m. | 40 mg. | haloperidol |
| 5:50 p.m. | 15 mg. | haloperidol |
| 6:30 p.m. | 15 mg. | haloperidol |
| **Monday June 23, 1980** | | |
| 1:00 p.m. | 20 mg. | haloperidol |
| 2:00 p.m. | 100 mg. | methotrimeprazine |
| 3:00 p.m. | 20 mg. | haloperidol |
| 3:30 p.m. | 100 mg. | methotrimeprazine |
| 3:55 p.m. | 50 mg. | diazepam (intravenous) |

Aldo was found with no vital signs at 5:05 p.m., and pronounced dead at 6:12 p.m.

in testimony, it was a reasonable finding, and their recommendations were sensible.

* * *

However, our coalition was still determined to get our information before the public in some way. Consequently, we decided to continue to work together in preparing a brief and asking for a meeting with Ontario Health Minister Dennis Timbrell to request a public investigation of treatment practices in Ontario psychiatric institutions. We felt we could demonstrate that Aldo Alviani was not an isolated case of psychiatric bungling--that the slipshod and inexcusable treatment which led to his death is commonplace in Ontario institutions.

Our first letter to Mr. Timbrell was--eventually--answered by a letter from one of his subordinates which (in polite terms) thanked us for our interest and suggested we leave this sort of thing to the doctors.

We wrote a second letter, accompanied by our brief, and also released the brief to the press. A lengthy story in the *Globe and Mail* about our concerns was followed by editorials in both the *Globe and Mail* and the *Star* supporting our call for an inquiry.

Meanwhile, both Ontario opposition parties took up our call for an inquiry. Mike Breaugh of the NDP and Sean Conway of the Liberals expressed grave concerns about the psychiatric system, and requested either a Royal Commission or a parliamentary inquiry.

In the middle of all this, the Toronto *Sun* released a story about an internal Queen Street memo resulting from a "Think Tank" of Queen Street psychiatrists, in which they admitted that the level of care at Queen Street left much to be desired.

Eventually bowing to all this pressure, the Ministry finally agreed to meet with our coalition (although the Minister himself is still unavailable--we've been delegated to the head of the Psychiatric Hospitals Branch). As we go to press, we're also preparing for this meeting.

We hope that the next issue of PHOENIX RISING will be able to announce the date of a public investigation into all aspects of psychiatric care in Ontario, with testimony from inmates and ex-inmates as one of its most important components. Our coalition is going to hang in there until we get it--and once we do, we've got a lot to say.

# *Brief attack on feds*

Last fall ON OUR OWN presented a brief which blasted the federal government for not cracking down on the pill-pushing doctors and drug manufacturers who've been handing out damaging tranquillizers and antidepressants--especially phenothiazines--like candy.

Don Weitz, ON OUR OWN's Project Co-ordinator, read the brief at a public hearing of the House of Commons Special Committee on the Disabled and Handicapped in Toronto on September 12.

The brief, entitled "Damaging Psychiatric Treatment: Some Observations and Recommendation", put forward three recommendations:

(1) Health and Welfare Canada should be severely restricting or totally prohibiting the manufacture and distribution of many psychiatric drugs, partifularly the phenothiazines.

(2) The federal government should investigate the use of electroconvulsive therapy, psychiatric drugs and behaviour modification programs in all prisons and hospitals under federal jurisdiction. This investigation should include taking personal testimony from prisoners and psychiatric inmates.

(3) The Department of the Attorney General should actively seek out cases in which

*At a Book & Bake Sale last fall, The Mad Market made $200.00. LEFT: John Craven presides over coffee. CENTRE: Susan Steele and manager Coreen Gilligan prepare for the onslaught. RIGHT: customers browse among hundreds of books for sale.*

Tony Myers

Find out more about ON OUR OWN! Call us at (416)-362-3193, or write to: ON OUR OWN, Box 7251, Station A, Toronto, Ontario M5W 1X9.

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medical practitioners have improperly treated non-consenting patients, or consenting patients whose consent is not fully informed and voluntary, and prosecute these practitioners--for example, by laying charges of assault.

If the government in its wisdom has the guts to act on any of the above recommendations, then PHOENIX RISING promises to honour it with our famous PHOENIX PHEATHER award.

*Susan Steele, one of ON OUR OWN's members, is now working in THE MAD MARKET under Manpower's Work Adjustment Program. She is working hard and doing an excellent job. Anyone wanting further information on the Work Adjustment Program or volunteer work in the store should call Coreen during store hours at 363-9807.*

At any rate, copies of the brief can be ordered by writing to ON OUR OWN, Box 7251, Station A, Toronto, Ontario M5W 1X9, or by calling us at (416)-362-3193. Each copy costs 50 cents, including a 25-cent mailing charge.

## GIVING THEM THE BIRD

In this issue, our awards honour two doctors--a cardiologist and a psychiatrist.

The PHOENIX PHEATHER goes to Dr. Alan Stewart of Brighton, England. While browsing in some surgery records at Brook General Hospital in London, Dr. Stewart discovered that four patients had had small segments of brain tissue destroyed by a procedure called "stereo tractotomy" without their knowledge. He spoke to the patients and their families, and eventually made a submission to the General Medical Council.

The Council, far from appreciating his concern, stated that Dr. Stewart had abused his professional position. The chairman of the disciplinary committee told him, "Your unauthorised, unnecessary and clandestine intervention might have jeopardised the relationship between two senior colleagues, their patients, and the patients' families."

It sounds to us like the kind of relationship that *ought* to be jeopardized. Anyway, Dr. Stewart, our thanks for trying, and a PHOENIX PHEATHER.

The TURKEY TAIL goes closer to home --to Toronto's very own Dr. Jerry Cooper. Dr. Cooper can add it to the trophy he probably has for being the most quoted psychiatrist in the history of the world (we suspect he's outdone even Sigmund Freud, at least in quantity).

It's been hard to pick a specific statement of Dr. Cooper's on which to base our award; there have been so many worthy of it. However, we finally settled on the advice he gave last month to women not to resist when someone is trying to rape them. This chauvinistic bit of advice appeared in the Toronto press shortly before a report of a study which indicated that women who resisted were likely to suffer *less* injury than women who did not.

Don't resist this award, Dr. Cooper--just lie back and enjoy it.

## PUBLICATIONS AVAILABLE FROM ON OUR OWN

**Consumer's Guide to Psychiatric Medication** (published by Project Release, New York). A concise and thorough description of psychiatric drugs and their effects and side-effects. $2.50.

**Myths of Mental Illness** (PHOENIX RISING Publication #1). An exploration of common beliefs about the "mentally ill"--are they really true? $1.00.

**Antipsychiatry Directory.** An up-to-date list of patient-controlled groups and journals around the world. (Printed periodically in PHOENIX RISING.) 50¢.

**On Our Own: Patient-Controlled Alternatives to the Mental Health System,** by Judi Chamberlin (McGraw-Hill Ryerson). "Required reading for all 'mental health' professionals ... who still believe that 'mental patients' are too 'sick', helpless and incompetent to run their own lives. $5.00 (list price $6.95).

**The History of Shock Treatment,** edited by Leonard Roy Frank. A compelling and frightening collection of studies, first-person accounts, graphics and other material covering 40 years of shock treatment. $6.00.

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# Since *WOMEN AND MADNESS:* an interview with Phyllis Chesler

Credit: Lucie E. Curtiss

*Phyllis Chesler is an American feminist psychologist who is the author of* Women and Madness, *a 1972 book which was the first serious attempt to explore sexism in psychiatry. (This book and Dr. Chesler's latest book,* About Men, *are reviewed in this issue.) Dr. Chesler was interviewed for* PHOENIX RISING *by Cathy McPherson.*

*CATHY:* When did you first take an interest in women and madness?

*CHESLER:* When people ask me how long it took me to write that book, my answer to them is "all my life". I was not particularly thinking of doing a book until 1970. There had been a year of meetings of women who were in the American Psychological Association; they were called the Association of Women in Psychology.

I made a speech, which we agreed on roughly beforehand, before the American Psychological Association. I demanded $1,000,000 in reparation for all the women who had been harmed only in the last year--1969--by institutionalization. I calculated that figure based on five years of dues that professional women had paid to this organization.

I said it without statistics. I said that women were being labelled more than men, and once they were hospitalized or under treatment, the same biases and sexual stereotypes that had maddened them or made them angry were then used to crush them even further.

I said these things, but I didn't have the documentation to say them. The response from the professionals was outrage and laughter, and my response as a human being with a revolutionary spirit was that I would then prove that what I was saying was true.

They laughed, and I wrote the book.

When I was very young my mother took me to a psychiatrist because I was different. It was very early--six, seven, eight years old. I remember not liking one psychiatrist. Now if there was any kind of unconscious long-repressed linking motivation, maybe it was there.

*CATHY:* In what way were you different?

*CHESLER:* I was fiercely independent. I didn't listen to anyone else--had my nose buried in a book, and was probably in no way feminine. I don't think I was a tomboy; I was merely headstrong and not easy to manage. Most children, if they're not ruined, are like that. I luckily managed to survive a very restrictive family life.

*CATHY:* After your book *Women and Madness* was published, were you swamped with calls from women who identified with women in the book?

*CHESLER:* Yes. Just three nights ago I had coffee with a friend and two other women on

their way to a meeting. At the end of the coffee, one of them kind of held my arm and stopped me on the way to the door, and said to me, "Your book meant a great deal to me." I said, "Thank you," and she said, "You see, I read it when I was in a mental hospital, and it helped me to get out."

When women tell me that, I say I have been privileged to save some lives. That is the most humbling flattery I have got about this book.

*CATHY:* Did you receive any crank calls or nasty letters about the book?

*CHESLER:* I got some. Most of the reviews were enormously positive. A few were scathingly negative, but they were in the minority. Most scathing or contemptuous opinions came from professionals who were threatened by it and feeling that they were guilty, that they had killed people, and that therefore I had to be excluded or disbelieved. Or, because they thought they'd lose customers and they wanted to hold onto them, I had to be disputed or disbelieved.

I have been sued over the years a number of times by psychiatrists. Once it was over the issue of sex between patient and therapist.

*CATHY:* Has your book changed anything?

*CHESLER:* The liberal in me must concede that it's certainly changed a lot--not enough. It's changed a lot of women who are either therapists, social workers, nurses, psychiatrists or psychologists, and women who are clients or inmates or prisoners or patients--how we view ourselves and what we mean by getting help. I don't believe it has changed the structure of state mental asylums anywhere. I don't believe it's stopped anyone from tranquillizing people badly or against their will, beating them, isolating them, giving them bad therapy or no therapy. I don't think it's prevented anyone from giving shock therapy.

*CATHY:* Have you been doing any rabble-rousing since the 1970 speech to the American Psychological Association?

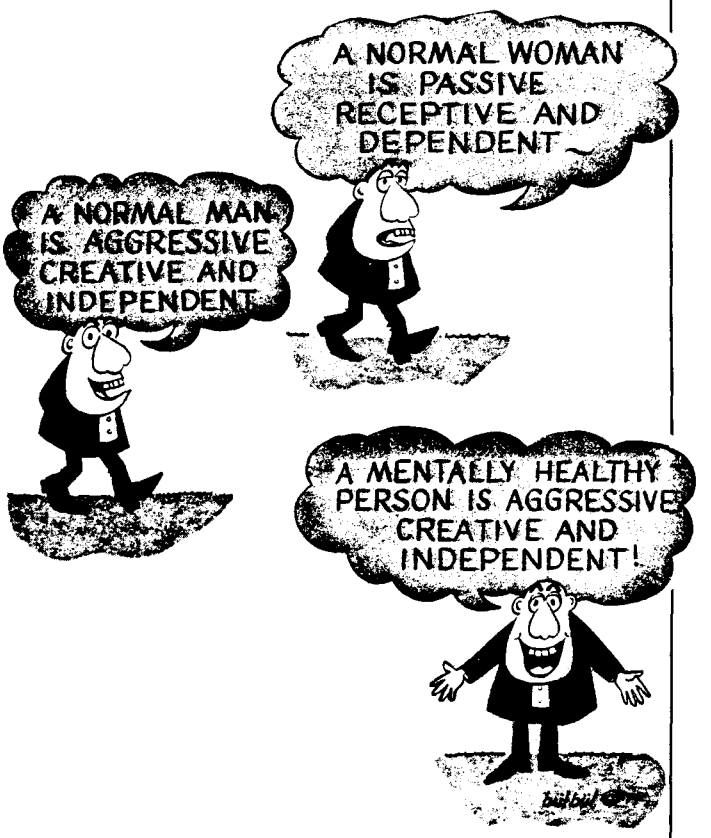
*CHESLER:* I have been going non-stop. I think that my power is at its best and most useful in books. I think that a word carries more effectively on a page. I also do sometimes lecture, or I do benefits; there are, though, fewer of them to do. People are nationally at the moment in a state of stunned apathy and in economic terror, and not having a lot of chic or non-chic feminist or radical events.

Rabble rousing--let me say this. I can only be an *ally* of people who have been in mental hospitals; I cannot lead them. They can use what I say. They can ask me to align myself, or use my credentials or my body to protect something they've decided they want. But I don't think I'm needed any more--nor was I ever--to give them a sense of great outrage or distrust.

*CATHY:* What do you think of Nathan Kline, the father of the chemical approach to problems, and his belief that our society is so stressful that few people can cope without drugs--so we might as well take them and enjoy life?

*CHESLER:* Then he hasn't been given a dose of Thorazine that makes his speech slurred, or his jaw slack, or his hands droop. I know it depends on which drug and how long, whether you know what the consequences are and then are willing to live with them. I would not, for puritanical or heroic revolutionary reasons, withhold a tranquillizer from someone who wanted it and was willing to accept his own long-term addiction and side effects. I think it is truly everyone's right to find the ways to survive that hopefully will cause the least amount of pain.

There are a few books that I haven't read, but they've been called to my attention, in which pills are highly recommended--if they are given out preferably by nice male psychiatrists to women who are depressed. Now this can be dangerous. Lithium, which does




work--I've seen it work--can and does have side effects, some of them most unpleasant, some of them dangerous. I am not positive there is one best treatment or choice.

*CATHY:* I think there is, though, a tendency nowadays to find an easy out.

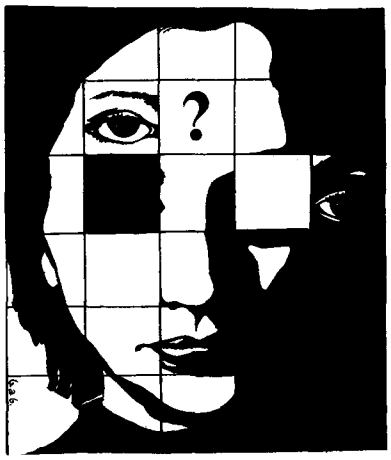
*CHESLER:* I think it's always been there. People have always been dreadfully conformist. Female people have always feared free-

dom. People have always chosen craven security over freedom; people have acted for reasons of security and safety and safe quick definitions of self. People have always looked for escapist distractions, rather than facing squarely the facts of our death or the nature of carving meaning in our lives. That's the human race.

*CATHY:* Do you counsel men or women or both right now?

*CHESLER:* I have counselled men. I've even tried a group of men and women. I attract women more than I attract men. I feel more passionately about women getting strong than I do about men getting strong.

Men are also very difficult for a woman to handle, because they don't like listening to women doctors. They don't like revealing emotional truths. They don't want to come to a feminist and admit they have a problem with women.



graphic by Ange. Byjczyk

Men reject, more than women do, the idea that there's help inside you, or that you can say what's bothering you. They look for the same kind of relationship that most women do, but when they look for it they might be terrified going to a feminist.

*CATHY:* How do you handle clients who come to you who don't have very much money?

*CHESLER:* It's not a big problem, because I have a very small practice. If and when I decide to do something full-time, then I would clearly have a sliding scale.

*CATHY:* Do you encourage women who come to you to get into self-help groups or consciousness-raising groups?

*CHESLER:* Yes. But it's interesting--after a decade of feverish activity, there is again a reticence, a shyness, a marked fear of getting into groups--and also the phenomenon of being hurt and burned by peers and other women and feminist groups and self-help groups. On the part of those who've been through it, there's a desire now for a little permission from parent figures to go and dare to trust other people.

Some graduate students and medical students consulted me about their fears, and I said, "Listen, you've got to make a group. Otherwise you are not going to make it through." But they're afraid of each other; they're afraid that the other women won't be loyal, true, and steadfast--will be superficial. Dependency is not possible. They want to have warmth that they can be sure of--one other woman they know they can trust, rather than count on a group process that may not be perfect.

Women want groups, but what I've observed, at least in New York, is a desire for something called a "more professional structure or approach"--whatever that means--and permission to be with each other for no money and with a certain moderate degree of expectation.

What I envision ideally is that there would be places, in the country and in the city, that are truly places for retreat, asylum, massage, nature, great understanding, and lots of space for women who are normal, because we need this as women. Women are un-

According to two Ontario university studies, middle-aged women who cannot cope with marital problems are most vulnerable to being prescribed tranquillizers.

A study by the University of Ottawa found that women between 45 and 65 received the most new tranquillizer prescriptions, while another study by Queen's University in Kingston found that women were about 30% more likely than men to be treated with tranquillizers for what physicians perceived as psychological problems.

The results of these studies, carried out in the late 1970s, were presented to members of the College of Family Physicians in May of last year. They confirmed earlier data collected by medical sociologist Ruth Cooperstock of Toronto's Addiction Research Foundation, who found that women receive almost twice as many prescriptions for psychotropic drugs as do men.

*See PHOENIX RISING, vol. 1, no. 1, for a column by Ms. Cooperstock on the use of Valium (diazepam).*


*"Well this ought to keep our bridge club stoned for at least three months."*

der severe stress. For women who slip--unable to deal with and handle it any more--the attention should be there.

*CATHY:* How would you counsel women who come to see you?

*CHESLER:* I have a couple of philosophical biases. I don't think women can in many ways see reality clearly, or cope with that reality, if they don't in some way see things as feminists.

That does not mean that if you go to a feminist you'll be happier, or that you'll never be hurt. On the contrary. With growing awareness, knowledge and understanding that a lot of these things are quite impersonal, that is humiliating in itself. Any woman who is not in some way a little paranoid is crazy!

*CATHY:* What kind of woman goes crazy today? Are you getting a lot of women suffering from the fallout from leaving relationships or marriages when feminism was at its peak in the early 1970s?

*CHESLER:* I think what happens when a woman leaves a bad marriage is that her skills as a wife and mother are not given credit on the public job market. If she cannot get a job, or a good job; if she cannot provide for her children; if she loses them legally, or loses their respect and affection; if she is sexually starved because she is over 40 and no one wants her--such a woman, unless she is very devoted to work, very strong, or feels good about herself, may be depressed.

That doesn't mean she's "manic depressive". That doesn't mean she should necessarily get lithium, but that there are cruel and unusual punishments meted out to women over a certain age because they opted for freedom, or because they left the harem. Suffering and pain aren't just for women. Suffering and pain are definitely a part of any freedom fighter's experience in life.

*CATHY:* Can selfishness and compassion co-exist in women, as you suggest in *Women and Madness*?



*CHESLER:* Women have to learn to develop themselves by selfishness, and to make it very strong and cherish it, because only a very strong woman has something to give another woman--a weakened woman and a frightened woman doesn't.

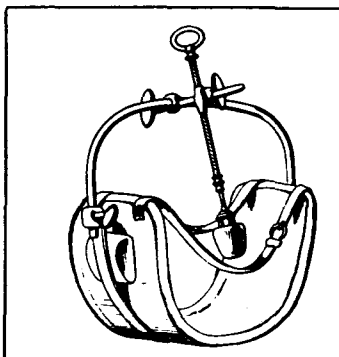
We have to dare to be selfish or aggressive or assertive, and not self-sacrificing, not masochistic, not martyred for the sake of children, for the sake of husbands, for the sake of religion, for the sake of family. At the same time we also have to learn how to love other women. That means to be cooperative with, to be able to be supportive to, to be deriving strength from other women, and to be compassionate to women in distress, which traditionally women have *not*

## The "good" old days

If we are allowed to hear of clitoridectomy at all, it is as the custom of faraway tribal people. Our horror and anger are set at a distance; we are taught to see 24 million circumcised women as victims living in some unimaginable Dark Age, not sisters in exploitation. Yet the last clitoridectomy in the West was performed as recently as 1953, in Kentucky, on a girl of 12.

The operation was popularised in the nineteenth century by a British doctor, Baker Brown, *as a cure for 'hysteria'--autonomous sexual desire, leading to every other form of rebellion and 'moral leprosy' in a woman.* The mortality rate from Baker Brown's operations was high, but not once did the medical profession oppose his right to kill a patient. He was finally expelled from the British Medical Association for advertising, and for performing surgery on one woman *without her husband's permission.*

*Reprinted from* Spare Rib, *no. 92, March 1980 from "How Can We Support Our Sisters?" Originally printed in* The Hosken Report, *a survey of clitoridectomy world-wide by Fran Hosken. This report can be obtained from The Women's Research and Resources Centre, 190 Upper St., London N1 England*



Ovary Compressor
(for the treatment of hysteria)

been. Women do not traditionally open the door to an abandoned woman, a poor woman, a raped woman, a battered woman. They close the door because they're afraid.

So at the same time as we have to be very strong and almost ruthless on behalf of our own survival, we have to learn how to be compassionate to other adult women. And this is only one of a hundred pairs of opposite tasks that women are faced with.

*CATHY:* What do you think of the recent brain research that seems to indicate there really are differences between men and women?

*CHESLER:* There is tremendous crossover between many women and men who in a sense psychologically cross-dress. By nature and by temperament, there are more differences within the same sex than similarities. Research on the brain, which I used to do--I worked in a brain research lab for three and a half years and was fascinated by it--is in a very, very primitive state. Culture is a far more powerful shaper of our destiny and our character than anything we know at this moment about genetics, or like to think we know.

There *may* be something there, but I don't think we can look at it until we truly do not penalize women for being different, better than, or the same as men culturally, which we now do. In other words, if there were truly equal opportunity, then we might see wonderfully, remarkably significant differences based on--I don't know: genitalia? hormones? But then again, whatever differences there are, there should never be any conclusion that one is inferior and one is superior, which is always the case.

*CATHY:* Has the birth of your son changed your attitudes toward men?

*CHESLER:* After *Women and Madness*, I wrote a book called *Women, Money and Power*. I thought I had gone as far as I could go into the psychological reasons for sexual discrimination, and that the answers to women must also include economic reasons.

My third book is called *About Men*, and it is a very beautiful prophetic meditation on men as seen by women. I said things in it that were true then and are true now, and remain unchanged by my son's birth.

What I have learned, however, is that men can leave a child without regrets, and that, amazingly, women have a much harder time doing that. I have learned that mothers try at any cost to remain committed to the relationship formed. Men feel a lot freer to break it.

*CATHY:* Are you raising your son in any special way?

*CHESLER:* It's very hard to figure out how to combat all the forces around a private soul; that means school, television, books ... . I try to love him, whoever he is, and then be prepared to let go. That would be enough.

## DEPO-PROVERA

istering it because it only has to be administered once every three months, leaving no chance for "slip-ups", and by women who associate it with "magic".

A controversy is brewing in the United States over an attempt by the Upjohn Drug Company to have the injectable contraceptive Depo-Provera accepted by the Food and Drug Administration.

Depo-Provera cannot be marketed in the United States, Canada, Sweden, Japan, India or Venezuela (although it is sold in about 70 countries throughout the world) because of evidence that it has caused breast cancer in dogs and uterine cancer in monkeys, in addition to other side effects such as weight gain, depression, menstrual interruption, and possible sterility. Upjohn is presently disputing that evidence.

But Depo-Provera *is* in use in some of these countries experimentally, in cancer treatment and in therapy with sex offenders, whose sex drives apparently drop with injections of the drug. It is also being used illicitly on "irresponsible"patients" such as the mentally retarded and the "mentally ill", particularly in Ontario where a moratorium prevents parents from having the mentally retarded sterilized before the age of 16.

In third world countries, where there are high birth and mortality rates, Depo-Provera is the contraceptive preferred by those admin-

# Do "crazy ladies" get raped?

It's not uncommon for women to be raped or sexually assaulted by orderlies or hospital staff when they enter a psychiatric institution, say women at the Toronto Rape Crisis Centre.

Counsellor Mariruth Morton told PHOENIX RISING, "It's a constant threat, not only from staff but also from other patients, due to overcrowding and lack of supervision. I've heard of multiple rapes by orderlies and staff myself and through some of the women who volunteer here." She named Whitby Psychiatric Hospital and the now-closed Lakeshore Psychi-


*"Now, honey, tell us again about this alleged rape."*

atric Hospital as two locales where such actions have taken place.

"I've had clients who talked about being in therapy and the therapy being a sexual relationship. I've also had several clients who've had problems with landlords in boarding and lodging houses," confirms Laura Row, another counsellor.

Women in boarding and lodging houses are particularly vulnerable to sexual assault because of the lax security often found in these premises and the high ratio of tenants to landlords.

In one boarding and lodging house for ex-psychiatric inmates in the Parkdale area, PHOENIX RISING has been told, a woman had another tenant enter her room and approach her twice before entering a third time and approaching her with no clothes on. None of the rooms had any locks on the doors. When she complained to her landlady and a social worker in the outpatient clinic at Queen Street, she received little sympathy and finally had to move out.

Lack of security is one reason that women leave rooming, boarding or lodging houses for Nellie's, says Hiljo Liitoja of Nellie's Hostel for Women. "They're bothered by other boarders. But it doesn't mean that they're raped--they may just be approached. The locks on their doors might not work."

But while locked doors might keep other tenants out of a woman's room, according to the Rape Crisis Centre landlords have been known to use their keys to let themselves into women's rooms to assault tenants.

In most of these cases, however, charges are not laid, because "crazy ladies" rarely have any credibility when testifying against those who assault them.

"That's the problem with that kind of assault," says Row. "You have a man who is an upstanding member of the community, and then you have a 'crazy lady' who has no credibility. But what I think is far more dangerous is the way women are taught to adjust--to take what's dished out to them. They're more likely to get tranquillizers, and more likely to be counselled to stay in abusive relationships."

"It's one time where victims have to prove their innocence," says Liitoja. "There's little chance of them winning their case, so there doesn't seem much point in laying charges."

# Women's bodies, men's decisions

by *Alison Sawyer*

Forced sterilization is the subject of much controversy in legal circles, among those concerned with minority rights, and among feminists. The controversy arises because sterilization is a surgical procedure and the person being sterilized must, in law, give his or her consent to the surgery. In practice, such sterilization is often done without the person's consent, or with only the consent of some third party--usually a parent, a doctor, or a hospital administrator.

Statistics on non-voluntary sterilization are hard to pin down. The public and politicians do not like to acknowledge that doctors still perform sterilization operations without their patients' consent. Of course, there are

stories.

I have, for example, the story of an acquaintance in Toronto, which confirms in my mind that forced sterilizations are done on unwitting welfare mothers, among others. In this case the woman had been in a mental in-

**"Doctors had been pressuring native women and welfare recipients into being sterilized"**

stitution, had two children, and at the age of 22 while on welfare went into hospital for an abortion. During the abortion, she was sterilized without her knowledge.

A Vancouver *Sun* story on March 11, 1977, on the joint meeting of the Advisory Councils on the Status of Women across Canada, reported that a delegate from Saskatchewan told those present that doctors in her province had been pressuring native women and welfare recepients into being sterilized when they were entering hospitals.

In 1976, a Roman Catholic missionary to the Northwest Territories revealed that one-third of Inuit women between the ages of 30 and 50 had been sterilized without being told and aginst their will. This was substantiated by similar statistics reported in a 1972 CBC public affairs program. The then Health Minister Marc Lalonde replied to such stories with a flat denial.

While the government of Canada may have been unwilling to acknowledge such blatant racism, the Government Accounting Office in Washington, D.C. reports all. The records of the United States Indian Health Service show that its doctors have sterilized thousands of native women without proper consent. On four reserves alone, 3,400 native women were sterilized over a four-year period in the 1970s. These women were not told that the operation was optional, not mandatory.

Forced sterilization of the mentally retarded has been a particularly contentious issue in the late 1970s. In Québec between 1976 and 1978, 500 mentally retarded people, most of whom were women, were reported sterilized. Similar reports come out of Ontario and British Columbia. And, despite a moratorium on sterilization of mentally retarded people below the age of 16, some illicit sterilization still goes on. A case from Prince Edward Island that will be decided on by the Supreme Court of Canada in the next two years could change the whole fabric of legislation on who has the right to give consent to a sterilization operation--you or your legal guardians.

* * *

Sterilization became an acceptable practice in the 1920s, when doctors and lawmakers turned to scientific procedures for controlling population. It was believed that the decision as to who was to be allowed to reproduce could be made on the basis of scientific assessment of who was physically, mentally and morally sound.

There was a fear among the male élite that those who did not measure up to their scientific assessment of who was fit might have higher reproductive capacities that the more desirable white, male-dominated middle classes. If left to their own devices, it was feared, they would reproduce unchecked. The genetic strain of undesirable characteristics would grown and streng-


then, and lead to an even higher population of this type that would threaten the genetic strain of the whites in power.

These fears, for which there is no scientific evidence, resulted in many jurisdictions

**"Between 1928 and 1972 forced sterilization was legal in Alberta"**

in Canada and the United States passing sterilization laws. For example, between 1928 and 1972 forced sterilization was legal in Alberta under the Alberta *Sterilization Act*. British Columbia had a similar piece of legislation in the same time period.

The Alberta *Act* set out five categories of people who could be sterilized:

--psychotic patients;
--mental defectives who suffered from arrested or incomplete development of mind which existed before they turned 18;
--individuals suffering from epilepsy with psychosis or mental deterioration;
--individuals suffering from neurosyphilis not responsive to treatment; and
--individuals suffering from Huntington's Chorea.

During the time the *Act* was in effect, some 2,500 patients were actually sterilized; 35.3% of them were male and 64.7% female. A study of how this *Act* was administered showed that a

greater proportion of eastern Europeans, Indians and Métis were sterilized than of the rest of the Alberta population.

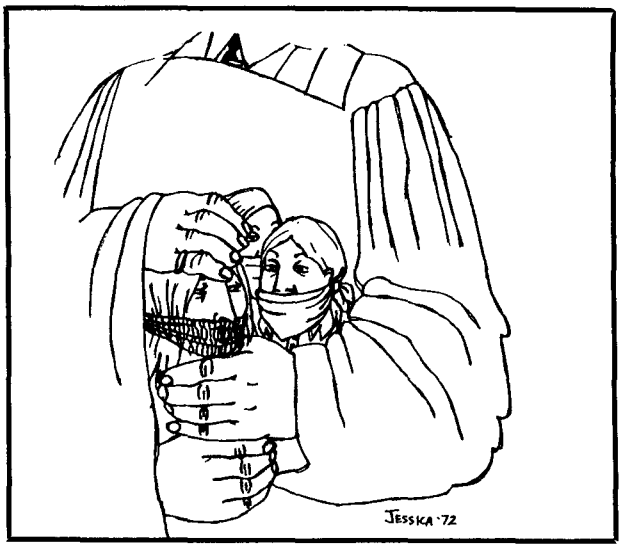
Under the Alberta law, a Eugenics Board decided who was capable of giving consent to sterilization. If the patient was considered incompetent, a spouse, a parent, a guardian, or the Minister of Health was required to consent.

In British Columbia, the Eugenics Board had first to decide what was more specifically set out in the Alberta law. There had to be a unanimous decision by the Board

> *that procreation by the inmate (of a provincial institution) would be likely to produce children who by reason of inheritance would have a tendency to serious mental disease or deficiency.*

In the United States, 32 states had similar legislation. In Virginia it is reported that 8,000 "mental patients" were legally sterilized between 1924 and 1972. The Virginia statute has not yet been repealed, although the state Board of Health has prohibited its use. The purpose of the *Act* is stated to be to prevent "racial degeneracy".

The laws written in the 1920s were based on inconclusive findings. But the very fact that legislation existed meant that authorities had to continue to look for justification for these laws. Although the scientific underpinnings have been shaken and the laws repealed, arguments are still made in favour of forced sterilization. These arguments have shifted from saying it would be of benefit to *society* (the hereditary not ons) to saying that sterilization would be of benefit to *those being sterilized*, to their parents, and to potential future children.




The shift in argument shows the male biases that are behind forced sterilization. In the early twentieth century, when the white male capitalists were still securing their hold over the rest of us, the genetic scientists provided the rationale. Now the capitalists, through the government, decide for themselves if and where the population should be controlled. This so-called "management of human resources" takes responsibility for decisions about child-bearing out of the control of individual men and women.

The government establishes standards to determine which sectors of the population should be sterilized. Almost without exception it is women who are chosen, whether they be on welfare or mentally handicapped.

The polite reasons given for sterilizing mentally handicapped women include, for example, to spare them from the "traumas" of mothering. It is a matter of foresight, it is said--a matter of avoiding the strain the potential children of such "unfit" mothers would put on community social services.

The real problems are thus not tackled. Men have always preferred to exploit and manipulate resources rather than to develop them wisely. So it is with their treatment of women.

Women's bodies are seen as resources to be controlled and exploited to meet the demands of the socio-economic system. The control of our bodies has been a long-standing feminist demand. It is the men in power who choose not to approach the socio-economic problems which make it impossible for all women to have fully developed self-determined lives.

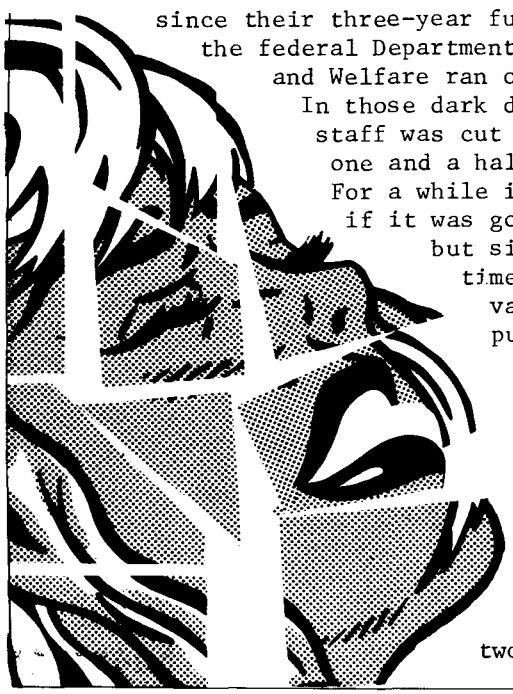
*Alison Sawyer is a lawyer now living in Vancouver, British Columbia.*

*(See this issue's* **Rights and Wrongs** *section on what to do if you or someone close to you is threatened with sterilization.)*

# profiles

## WCREC

It takes a special breed to stick it out over several years with next to no money while providing services to the community. But that's what Toronto's Women's Counselling, Referral and Education Centre has been doing since their three-year funding from the federal Department of Health and Welfare ran out in 1977. In those dark days, WCREC's staff was cut from six to one and a half positions. For a while it looked as if it was going to fold, but since that time, through a variety of public and private funding sources, WCREC has revitalized itself. It now supports two full-time and two part-time staff people. Sbout eight regular volunteers and an active board help hold down the fort. It's still a long way from where the WCREC collective would like to be financially, but it's in there fighting, gaining strength, and hoping that the Ontario Ministry of Health will see fit to provide it with enough money to carry on.

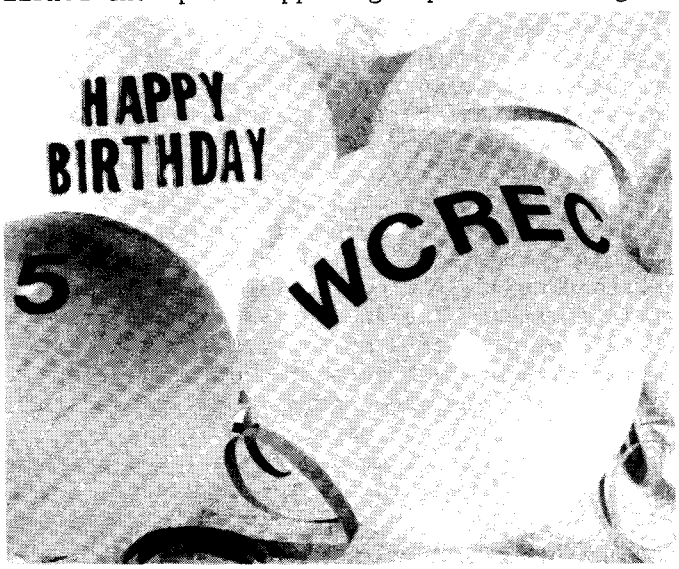


WCREC was started in 1974, when a group of about 15 women connected with the Clarke Institute of Psychiatry and social agencies banded together to do something about the quality of service--or lack of it--they saw being divvied out to women. They were concerned about the overuse of drugs in the therapy of women, and they sensed a need for a referral centre where women could have access to lists of non-sexist therapists and other resources necessary to their survival in the city.

During the early years, staff at WCREC screened non-sexist therapists, attempted to teach women the consumer approach in therapy, educated them on clients' rights, and attempted to stress a more holistic approach to therapy.

WCREC spent its time speaking to staff in hospitals, establishing a liaison with the Immigrant Centre that still exists, and helping create Support Services for Assaulted Women.

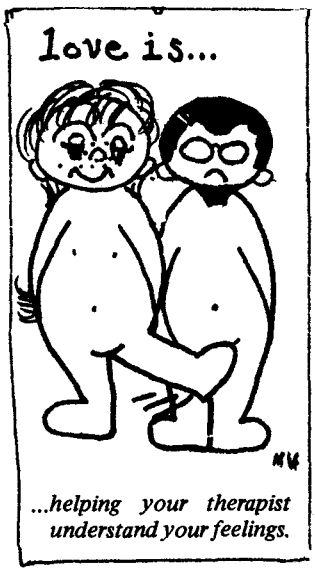
From the beginning WCREC recognized the need for self-help groups, and trained a self-help group collective, some of whom are still running either focussed or general self-help groups on their own today. WCREC also established therapist support groups to encourage




sharing of problems and information among the counsellors to whom they referred clients.

Although WCREC's hours and services have been drastically reduced, they still do referral and education, counsel women, and review therapists. They spend more time today finding therapists and support services for low-income women. For this reason WCREC no longer seeks out private therapists; instead, therapists come to them.

Therapists who approach WCREC are given a series of questions, and then are interviewed by two WCREC people who judge whether they are sexist. WCREC does not, and can not, attempt to analyze the quality of service these therapists provide. Women who come to WCREC are encouraged to shop around for the therapist who best suits their needs.




Lately WCREC has been moving more and more in the direction of self-help and outreach programs, as they find many of their clients unable to pay the surcharges over OHIP that many psychiatrists are now charging.

A staff person has been working with Interval House (a refuge for battered women and their children) to start in-house groups. The Toronto Rape Crisis Centre has also expressed interest in starting self-help groups, and will be working with WCREC in early 1981 to get some groups off the ground. WCREC itself has also started a self-help group in its own facilities for low-income women who want individual support through a group; it's called Target Self-Help.

"Self-help groups are 'leaderful' groups," explains staffer Maureen Whyte. "The group evolves its own structure, how long it wants to meet, etc. The kind of things they may want to work on vary. It may be personal, or general consciousness-raising." But, says Whyte, "People are allowed to work at their own rate. The ground rule must be protection, so you can say whatever you want without being dumped on."

Jackie Yeomans, who believes the number of opted-out psychiatrists in Metro is higher than the provincial figure of 18%, says interest in joining self-help groups works a number of ways. "A lot of women won't have anything but self-help because they've been burned by their therapists. Some people go into therapy and then into self-help groups, or do both things at the same time."

WCREC has recently helped set up a Women's Services Network with other women's service groups in Toronto to help better serve the needs of low-income women. It is also negotiating with an American women's group to bring up a special videotape production on survivors of incest for a workshop planned in 1981.

On the agenda in 1981 will be the release of a new paperback, called *Through the Therapy Maze*, which deals with menopause, drugs, the philosophy of shopping for a therapist, and other issues faced by women in therapy. Also watch for the commercial release of WCREC's *Chcosing a Therapist*, a comprehensive listing of non-sexist therapists to whom WCREC refers its clients, and what they charge. Omitted are low-cost therapists for special needs clients. This book, presently sold to women's groups for reference only, could be available to the general public in 1981.

Women interested in contacting WCREC about their programs and services can call 924-0766 between 1 p.m. and 4 p.m., Monday through Friday.

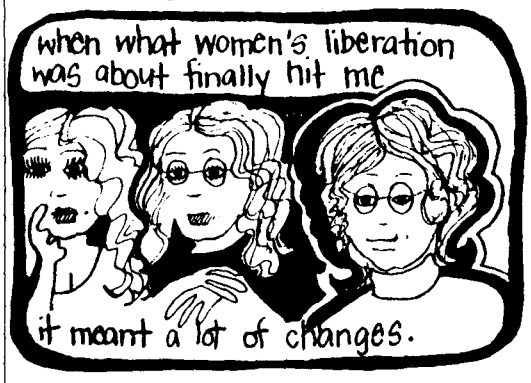
# WAPA

*by* Arrow

Women Against Psychiatric Assault (WAPA) was originally started in 1975 by two feminist halfway-house workers who were active in the Network Against Psychiatric Assault (NAPA) in San Francisco. Although there were several former "mental patients" in this original group, myself included, the women who were not ex-inmates dominated it.

WAPA remained fairly small until the two

halfway-house workers attended a conference on Women and Mental Health. One of the ex-inmates in WAPA, Lily, had asked the organizers of this conference if any attempt had been made to reach women who were former psychiatric inmates or former prisoners. She was told that "people like that" would not be interested in the conference (or presumably welcome). After this conference, a lot of new women joined WAPA, all of them mental health professionals. I went to one or two of these large meetings of professionals. By this time the other ex-inmates had dropped out. The topics of conversation ranged from things like when it is "appropriate" to commit someone, to the value of Lithium in treating "manic depression".




I was revolted by their lack of consciousness and said so. They were thrilled to have a real mental patient in their midst (although in general they believed that ex-patients were "too sick" to take an active role in WAPA, and should be relegated to some sort of therapy group) and they encouraged me to come back. I declined the invitation.

However, my contact with them was not over. NAPA, which I was working with, was at the time organizing a number of seminars and demonstrations against electro-shock treatment, which is used primarily against women. We invited these women from WAPA to join our demonstrations. They replied that they didn't know enough about shock treatment to take a position on it. (This was not true of the two paraprofessionals who started WAPA, who were strongly against all coercive treatments.) We invited them to a seminar on shock but they all said they were too busy to make it (and presumably too busy to read the materials about the damaging effects of shock which NAPA had available). On the day of our demonstration against shock treatment at Herrick Hospital, as we marched from Ho Chi Minh Park to the hospital, we passed two of the therapists who were the most active in WAPA. We waved and cried "Join us! Join us!" They looked at us blankly.

A few months later, the Third Annual Conference on Human Rights and Psychiatric Oppression was held in San Francisco, organized by NAPA. There the contradictions between ex-inmates and "mental health" workers were even more apparent. Numerous radical therapists and psychiatric workers had been asked to lead workshops on things like "bioenergetics" and "psychiatry in Cuba" (since no ex-mental patients could afford to travel to Cuba).

A large number of people from San Francisco came to the conference to find out about radical therapy who had no interest in, or understanding of, the oppression faced by psychiatric inmates. The ex-inmates who had travelled from all parts of North America to strategize with and get support from each other found themselves once again being ignored and put down by professionals. Two of the ex-inmates from out of town were outraged by this situation and went to all the workshops, inviting ex-inmates to join them in an "ex-inmates only" caucus. About 50 of us did, and the autonomous North American ex-inmates' movement was born. After that, a lot of ex-inmates in NAPA decided to put most of our energy into reaching out to other ex-inmates.

I started a support group for women who were former psychiatric inmates in my apartment. At first, the women who came were very much tied into the psychiatric system, taking drugs and seeing shrinks, and expecting the group to provide them with "services". However, gradually some other women joined who saw the group as a place for ex-inmates to hang out together as equals, and help each other as part of a collective process, with no authority figures.


One of the women in the group, Ahni, had some contacts with the magazine *Country Women*, and they asked her if we would like to write some articles for them about our experiences as inmates and also some political analysis. At that point we closed the group to new members and put all of our effort into writing and discussing the articles. *Country Women* decided our politics were too radical (since we rejected completely the concepts of mental illness and professional expertise) and they only printed Ahni's article. The other articles were subsequently printed in *Madness Network News (vol. 3, no. 6)*. By that time we had inherited

the name WAPA, since the original WAPA had disbanded, being unable to find a focus for the group.

Our next project was organizing a consciousness-raising group of women ex-inmates through "Breakaway", a women's free school.

# *After the Conference one of the most active members was kidnapped.*

Some of the women who came expected the organizers to take a strong leadership role and were disappointed. However, there were one or two women in it who became part of the ongoing and loosely-structured network that was WAPA.

The next project happened very spontaneously. NAPA was organizing a demonstration to protest the forced shock treatment of a 17-year-old woman. As sometimes happens in collectives, no one had really taken responsibility for publicizing it.

WAPA decided to write our own leaflet, directed to the women's community, pointing out how shock treatment is used to control and terrorize women, and make wealthy male shock doctors wealthier. Our leaflet brought a tremendous response, and about 80 women showed up. (The patient being shocked was released soon afterward.)


Up to that time we had refused to allow non-ex-inmates into the group for fear of them dominating it as they had the original group. After this demonstration we changed our policy, and sent a letter to all the women who had signed the mailing list during the demonstration, asking them to a meeting. Almost none of them came, but a handful of women ex-inmates who had not been at the demonstration showed up, and one non-ex-inmate who had been wanting to join for a long time, and who became one of the main organizers for WAPA.

That summer, NAPA and WAPA organized a month-long sit-in at Governor Brown's office, to protest forced labor without pay and forced treatment in psychiatric institutions. When we were asked to leave the governor's office to meet with Governor Brown in the plush home of the head of the Department of Health, the women elected to remain in the office, since we knew that if everyone left we would be locked out and the sit-in would be over. Our persistence paid off; ten days later we held a Tribunal on Psychiatric Crimes in the governor's office, which was attended by 150 people, and received a lot of media attention. Two members of WAPA videotaped the tribunal.

After we returned to the Bay Area from the capitol, we were asked by the organizers of a Conference on Violence Against Women to do some workshops on psychiatric violence against women. For a period of several months, ten or eleven of

## EXISTING WOMEN'S ANTIPSYCHIATRY GROUPS

*COALITION TO STOP INSTITUTIONAL VIOLENCE*, c/o Women's Center, 46 Pleasant St., Cambridge, MA 02139

*ELIZABETH STONE HOUSE*, 108 Brookside Ave., Jamaica Plain, MA 02130

*FEMINIST INVESTIGATIONS IN "MENTAL HEALTH"*, National NOW Task Force, P.O. Box 5075, San Francisco, CA 94101

*HERA FEMINIST PSYCHOTHERAPY COLLECTIVE*, P.O. Box 28, Iowa City, IA 52240

*SUPPORT FOR WOMEN IN MADNESS*, c/o Las Hermanas, 4003 Wabash, San Diego, CA 92104

*WOMEN AGAINST PSYCHIATRIC ASSAULT/DENVER*, c/o Woman to Woman Bookstore, 2023 Colfax Ave., Denver, CO 80206

*WOMEN AGAINST PSYCHIATRIC ASSAULT*, P.O. Box 3921, Hollywood Station, CA 90028

*WOMEN AND MENTAL HEALTH/NATIONAL ORGANIZATION FOR WOMEN*, 425 13th St. NW, #1048, Washington, DC 20004

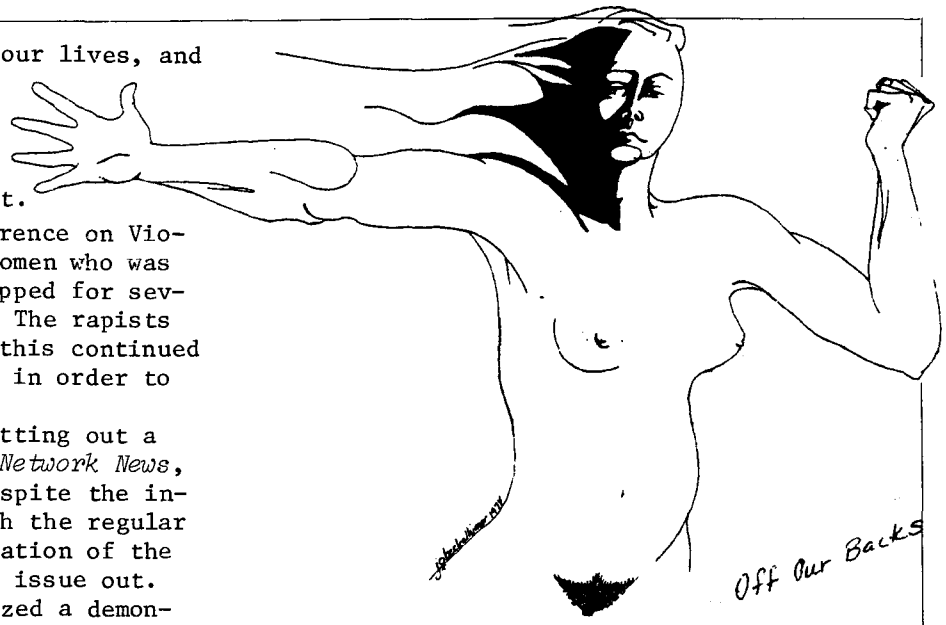
*WOMEN'S MENTAL HEALTH PROJECT*, 1915 NE Everett, Portland, OR 97232

us met every week, sharing food, our lives, and spending some time each week planning the workshops. For me, this was the most successful period of WAPA's history, in terms of giving each other support.

Several days after the Conference on Violence Against Women, one of the women who was the most active in WAPA was kidnapped for several hours by two men and raped. The rapists began harassing her by phone and this continued for months. This woman left town in order to avoid the harassment.

WAPA was in the middle of putting out a special women's issue of *Madness Network News*, a very controversial project. Despite the intense struggles around sexism with the regular staff, and the beginning fragmentation of the women's group, somehow we got the issue out. During this time WAPA also organized a demonstration at the state capitol to protest the extradition of a Chicana lesbian back to a Colorado psychiatric institution. Although we failed to prevent the extradition, the publicity probably helped in securing her release soon after she was returned to Colorado. The women's issue of *Madness (vol. 4, no. 3)* was really good, and it was the last formal project that WAPA did.

One or two attempts have been made to revive WAPA, and there was a new women's support group that lasted several months, but WAPA as a distinct community no longer exists. Since WAPA's demise, the ex-patients who were in it have done or are now doing the following: going to graduate school in holistic health and educating students and teachers about psychiatric oppression; confronting the women's community about their elitism towards former inmates and being involved in a feminist coven; working as a substitute teacher in ghetto




schools; studying healing among native people; perfecting methods of ripping off the capitalist system; working as a printer; doing house construction; working in a child care center; repairing computers; studying film-making and starting a lesbian dating service; working in social services in a medical hospital and being active in her union; starting a refuge for battered women in her home town. Two are working as secretaries in a local university. Three are raising children. Three of us are still actively involved in the anti-psychiatry movement and *Madness Network News*.

Various members have maintained private friendships. None that I know of have returned to a psychiatric institution. When people ask us if WAPA still exists, we smile and say, "WAPA is a state of mind ... ."

*WAPA members can be reached c/o* Madness Network News, *P.O. Box 684, San Francisco, CA 94101.*

# phoenix pharmacy

## LITHIUM

Lithium carbonate has been touted as the latest miracle drug, the best answer doctors have to the highs of "manic depression". PHOENIX RISING does not want to enter into a debate as to whether lithium "works"; the evidence is conflicting. What we want to do in this column is to point out that, even if lithium *does* "work", it does so at a price that you may not be willing to pay.

Lithium is unlike most psychiatric drugs--in fact, most drugs--in being a metal; it has properties similar to those of sodium and potassium. It is used by psychiatrists in the form of lithium carbonate, a metallic salt.

In Canada it is available under several brand names--Lithane, Lithizine, Carbolith and Lithotabs.

No one knows lithium "works". What known is that, in order to "work", the level of lithium in the blood must be very close to the toxic level--the level at which one's body is being poisoned by the drug. Consequently, a person taking lithium must be closely monitored to make sure that the blood level is not too high.

There is evidence that when lithium is used with certain other drugs such as mazindol (an appetite suppressant), haloperidol (Haldol), fluphenazine (Moditen, Modicate or Prolixin) or flupenthixol (Fluanxol), the toxic level is reached much earlier. In fact, there have been some cases in which lithium used with haloperidol has been associated with attacks like encephalitis and followed by irreversible brain damage.

The dangers of a toxic dose of lithium are very real. In one study of 23 toxic patients, two died, two more had persistent neurological damage, and 18 had temporary abnormalities in their EKGs (measurement of heart function).

But even below the toxic level, lithium has drastic effects on the body. Many of these effects are even worse in people taking lithium along with other psychiatric drugs. What follows is a list of some of the effects of lithium on various organs and systems of the body.

Neuromuscular effects. In one study, over 40% of those receiving lithium at the correct level developed hand tremors. Other effects include twitching; inability to coordinate voluntary movements; general muscle weakness; and irregular involuntary contractions of the muscles. Most of these effects occur much more frequently in people also taking other psychiatric drugs.

Effects on the central nervous system. People on lithium often experience slurred speech, dizziness, drowsiness, slowed movement, restlessness, confusion, and loss of feeling in the skin. More serious effects include blackouts, seizures resembling epileptic attacks, loss of control over urination and defecation, and coma. There is some evidence of memory loss, and strong evidence that when lithium is used along with ECT (shock treatment), memory loss and other neurological damage is much greater than with ECT alone. Lithium used with other psychiatric drugs may cause sleepwalking.

Effects on the cardiovascular system. Lithium can cause irregular heartbeat, lowered blood pressure, loss of circulation to bodily extremities, changes in the EKG, and heart failure.

Effects on the gastrointestinal system. Lithium use can result in severe loss of appetite, weight loss, vomiting and abdominal



★ Smith Kline and French has announced the appointment of David Cook, M.D., as its new Director of Clinical and Development Operations for the Canadian and Caribbean branches.

Dr. Cook will be responsible for planning, integration, and directing all pre-marketing clinical research operations for those areas.

PHOENIX RISING readers may wish to write to Dr. Cook to express their opinions on the marketing of Thorazine and their support of the boycott against SKF (see PHOENIX RISING, vol. 1, no. 2). Letters should be addressed to Dr. David Cook, c/o Smith Kline and French Canada Ltd., 1940 Argentia, Mississauga, Ont.

pain. In one study, over 13% of subjects experienced nausea, over 14% had diarrhea, and over 18% were constipated. About one-third had excessive thirst, and about one-third complained of dryness of the mouth. These last two effects were much greater (50% to 60%) in people taking other psychiatric drugs along with lithium.

Effects on the genitourinary system. An abnormal amount of albumin, iron, and/or sugar may appear in the urine. Over 40% of subjects in one study reported excessive urination. In other studies with long-term users, 25% had a lowered ability to concentrate urine, and 40% developed cysts on the kidneys.

Effects on the skin and hair. The skin may dry out, become itchy, and/or develop a rash. Psoriasis may worsen. As already mentioned, there may be a loss of feeling in the skin. The hair can become dry and thin out, and hair follicles become chronically inflamed. Baldness may result.

Effects on the thyroid gland. Lithium may cause goitre, or cause the thyroid to become underactive (or occasionally overactive).

Effects on the blood. Lithium can cause anaemia. It can also bring about a temporary increase in the number of white corpuscles. There is now evidence that it may cause acute monocytic leukemia.

Other effects. Other effects include blurred vision, fatigue, lethargy, temporary impairment of vision, dehydration, allergic inflammation of the blood vessels, leg ulcers, metallic taste, sweating, infection, and ringing in the ears.

What is even more disturbing than these *known* effects of lithium is some other information drawn from standard reference works used by physicians and pharmacists. There have as yet been *no* long-term studies of the toxic effect of lithium in animals. Lithium is not recommended for use by children or by pregnant women because there is *not* enough information about its effects on children or fetuses. And there is *no* specific antidote for lithium poisoning; all that can be done if someone has received a toxic dose is to try to remove the lithium from the body as quickly as possible.

As with any other psychiatric drug, lithium should *not* be stopped "cold turkey". If you are taking lithium and wish to stop, DO SO UNDER THE SUPERVISION OF A PHYSICIAN, who will be alert to symptoms of withdrawal and able to treat them.

*REFERENCES: A PARTIAL LIST*

Small, J.G.; Kellams, J.J.; Milstein, V.; and Small, I.F. Complications with electroconvulsive treatment combined with lithium. *Biological Psychiatry* 15:103-111 (1980).

Hansen, H.E.; Hestbech, J.; Sorensen, J.L.; Nørgaard, K.; Heilskov, J.; and Amdisen, A. Chronic interstitial nephropathy in patients on long-term lithium treatment. *Quarterly Journal of Medicine* 48:577-591 (1979).

Bone, S.; Roose, S.P.; Dunner, D.L.; and Fieve, R.R. Incidence of side effects in patients on long-term lithium therapy. *American Journal of Psychiatry* 137:103-104 (1980).

Hammond, W.P. IV, and Applebaum, F. Letter: Lithium and acute monocytic leukemia. *New England Journal of Medicine* 302:808 (1980).

Charney, D.S.; Kales, A.; Soldatos, C.; and Nelson, C. Somnambulistic-like episodes secondary to combined lithium-neuroleptic treatment. *British Journal of Psychiatry* 135:418-424 (1979).

Vestergaard, P.; Amidsen, A.; Hansen, H.E.; and Schou, M. Lithium treatment and kidney function. *Acta psychiatrica scandinavica* 60:504-520 (1979).

In its Annual Report issued in June 1979, the Canadian Medical Protective Association reports an "extremely large" settlement it made on behalf of a patient treated with lithium.

The situation arose in 1971, when a woman was seen on an emergency basis by the psychiatrist. She gave lithium carbonate pills to the patient, in spite of the fact that at the time it was not widely used, and the pills given to the patient were supposed to be used in a specific clinical trial. The patient was told to take a 300-mg. pill four times a day. No laboratory checks were ordered.

Two days later, a hospital emergency department, unaware of the lithium medication, prescribed another tranquillizer and sent the woman home.

Several days after this, the woman was admitted in a coma to a general hospital after having had severe epileptic seizures. A blood check showed extremely high levels of lithium, and resulting kidney failure.

Emergency treatment saved the woman's life, but she was left with incapacitating brain damage, and will require institutional care for the rest of her life.

Experts agreed that the psychiatrist had not met acceptable standards, particularly in not observing the precautions recommended when lithium is prescribed.

## SID CAESAR ON DRUGS

I was the walking dead for 18 years. ... And it's only been two years since I kicked my drug addiction. ... You know what (the shrinks) did for me? They put me to sleep instead of curing the problem, prescribing Valium and Equinol. After a while I was taking 50 milligrams of Valium a day. Whenever I took Valium, I took Equinol. ... Along with these heavy drugs, I was drinking pretty heavily too. And my doctors and the headshrinkers knew it. ... I took the pills. But the doctors made them available. The guys I really blame are the shrinks. ... Once the shrinks get you addicted to drugs, they own you lock, stock and barrel. They keep you coming back day after day, year after year, putting their kids through college on your neuroses and drug dependence on them.

--Quoted in the Toronto *Star*, Nov. 23, 1980.

## CANADIAN SHOCK DOCS UPDATE

Thanks to readers, we have four names to add to our list of Canadian Shock Docs. (The entire updated list will be published periodically in PHOENIX RISING.) The additions are:

Cornish, David. Alberta Hospital, Edmonton, Alberta.
Haden, Phil. Kingston Psychiatric Hospital, Kingston, Ontario.
Jeney, L. St. Joseph's Health Centre, Toronto, Ontario.
Stevenson, Gerald. Kingston Psychiatric Hospital, Kingston, Ontario.

If you, a member of your family, or a friend has received shock from a Canadian doctor and want his or her name added to our list, send us the name, hospital affiliation and city. PLEASE SIGN YOUR LETTER; we will not use names submitted anonymously. However, we will at your request withhold your name. Additions to the list should be sent to: Shock Doctor List, PHOENIX RISING, Box 7251, Station A, Toronto, Ontario M5W 1X9.

# what's happening

## Landmark Supreme Court ruling

A recent ruling by the Supreme Court of Canada may have far-reaching implications for the treatment of inmates in hospitals and psychiatric institutions. A unanimous decision by the Court in early December stated that patients have the right to be warned, without asking, of the risks facing them in surgery.

The case involved a Ford assembly-line worker who went to a doctor to get treatment for a plugged artery. Surgery resulted in a stroke which left him with a paralyzed right arm and a lame leg. But John Reibl was unable to get a full disability pension from Ford because he was two years short of the eligibility period. Reibl testified that if he had known the risks, he would have postponed the operation. He was awarded $225,000.

The ruling has yet to be tested in areas other than surgery. However, it could well mean that psychiatric inmates who have not been warned about the risks involved in drug treatment or electroshock therapy now have much better grounds to sue for damages.

# Five Canadians sue the CIA

Five Canadians are taking the CIA to court and asking for a total of $5,000,000 for the damage they suffered at the hands of a Montreal psychiatrist who administered LSD to them and conducted brainwashing experiments on them between 1957 and 1963.

The plaintiffs, Val Orlikow (wife of Manitoba MP David Orlikow), Jean Charles Page, Robert Logie, Jeanine Huard and Lillian Cameron, are seeking $1,000,000 each. They allege that the late Dr. Ewen Cameron, at that time chairman of the Department of Psychiatry at McGill University, got $60,000 of CIA money to run them through a series of experiments which included using LSD and massive dosages of electric shock--about 75 to 100 times that normally used.

All five report impaired mental health as a result of the experiments, in which none of them were told they were taking part.

Meanwhile, in the United States, a former army private who was unwittingly given LSD by a US intelligence officer to make him confess to an alleged theft has won $650,000 from the US government.

James Thomwell, 43, has been trying for 19 years to get compensation from the government for the mental damage he suffered from the drug. Thomwell, who lives in the San Francisco area, has worked only sporadically since his medical discharge from the army after taking the drug. According to his lawyer, he will probably need psychiatric treatment for the rest of his life.

# Wither Whitby

Members of an advisory committee that helped pull together a report plotting how Whitby Psychiatric Hospital would be decentralized are holding their collective breath to see what Minister of Health Dennis Timbrell does with it.

Plans to rebuild the early twentieth century buildings, which once held over 1,500 inmates, have been halted until Timbrell goes over the report, handed to him before Christmas. (Because of the condition of its buildings, and a trend toward decentralization, Whitby now holds only about 400 inmates.)

The Planning and Priorities Advisory Committee for Whitby's catchment area worked on the report for a year. In the final analysis it doesn't look too bad from an inmate's point of view, although there has been a conspicuous absence of inmate participation on the committee itself and on the committees and councils planned to eventually decentralize Whitby.

As Mary Ellen Polak, social planning consultant for the Canadian Mental Health Association (CMHA), herself admits, the committee was heavily weighted with hospital representatives--from Scarborough Centennial, Oshawa General, York Central, and the Hospital Council of Metro--along with the administrator of Whitby Psychiatric. Representatives of Durham Regional Health Council and from Haliburton, Hayworth and Pine Ridge Health Councils also served on the committee, along with two people from the Ministry of Health and three CMHA representatives.

To CMHA's credit, they did spend time and money trying to allow inmates at least some say in the process. Unfortunately, few responded--perhaps because they realized that if they didn't have a say at the top, their opinions could be easily disregarded.

Nonetheless, despite the report's acceptance of the medical model and its use of the word "managed" in connection with inmates, it came out very strongly in favour of eventual community control of services, rather than Whitby control, and recognized the stigma attached to psychiatric facilities wherever they may be.

The committee also recognized the need for inmate self-help groups, although they did not make clear whether they saw these or any of the other recommended services as inmate-controlled.

The committee repeated over and over again the need to establish community services *before* decentralizing, to keep Whitby's size small (they didn't say *how* small), and to establish twenty-four-hour crisis centres in the Whitby area to keep patients out of hospitals (we knew it all the time!).

It remains to be seen, however, how the Ministry of Health decides to implement the plan, and whether they will in fact encourage the growth of community-controlled alternatives to supplement Whitby Psychiatric, or whether they will develop the concept of drug therapy clinics run by Whitby and other hospitals in the area to the exclusion of everything else.

# LWG'S in New Brunswick

## Emerson Bonner revisited

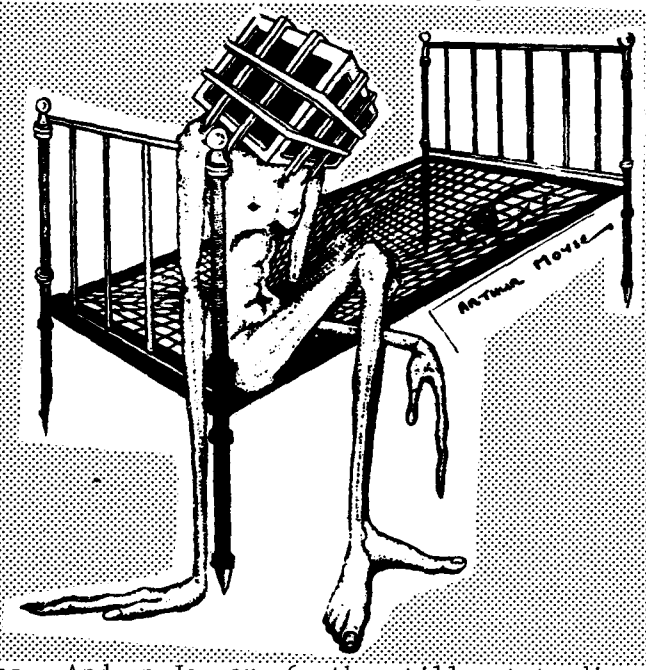
Emerson Bonnar is home at last.

As we told you in earlier issues of PHOENIX RISING, Mr. Bonnar tried to steal a woman's purse 16 years ago, when he was 19 years old. As a result, he was sent to a maximum-security psychiatric ward, and just forgotten about except by his mother, who has being trying ever since to get her son back.

It's taken almost a year and a lot of peo-

ple to win Mr. Bonnar his freedom. First, the story was picked up by the CBC *Ombudsman* program (since cancelled for dubious reasons). Then the Association for the Mentally Retarded got into the picture (Mr. Bonnar had been diagnosed as both "schizophrenic" and "mentally retarded"). Two independent psychiatric investigations concluded that he should probably never have been hospitalized in the first place. Even then, the New Brunswick Review Board relented only to the extent of moving him to a less secure (though still locked) ward where, according to staff, he was getting none of the treatment ordered to rehabilitate him after his 16 years of confinement.

Then suddenly the hospital announced that Mr. Bonnar could go home for 10 days at Christ-




mas. And on January 6, the still-outstanding charge against him was dropped, and the Lieutenant-Governor's Warrant lifted.

Mr. Bonnar will probably still have to spend some time as a civil patient in a psychiatric ward to accustom him to life on the outside before full release. But he'll be close to his mother in Fredericton, and for the first time in 16 years he knows it won't be long until he can leave the psychiatric system for good.

Congratulations, Emerson--and all the other people who have helped to right a grave injustice.

* * *

Mr. Bonnar's case has moved MP Neil Young (NDP--Beaches riding in Toronto) to announce that he intends to call for amendments to the Criminal Code ending the use of Lieutenant-Governor's Warrants. Best of luck, Mr. Young, in your efforts to end a barbaric institution which is presently keeping over 1,000 Canadians imprisoned with no assurance of ever being released.

# ...and in Ontario

## the Kowalski case

We've been keeping you informed on the New Brunswick case of Emerson Bonnar (see update in this section). It now appears that Ontario has its very own Bonnar case at Penetanguishene.

Henry Kowalski had been in Queen Street Mental Health Centre for two years when he was transferred to Penetanguishene for "better treatment" while Queen Street was being rebuilt in 1972.

According to the Kowalski family lawyer, John Weingust, his family was told he would be there only two months.

"They said they were transferring him to a better facility," says Weingust. "The Kowalskis never gave their consent to do it. When they went down there to visit they were completely shocked."

What they saw was Henry living in an 8-foot by 10-foot cement cell, and mingling with inmates who had been put there because they were considered criminally insane.

The Kowalskis, who live in Toronto, have been fighting for eight years to get their son out of Penetanguishene and back into Queen Street or the Clarke Institute, where they can visit him more easily, but so far with no luck.

A review of the case by the Ministry of Health in November decided that he should continue to receive treatment at Penetanguishene, or be transferred to a medium security unit in either Brockville or St. Thomas, even though he has never committed a crime.

"They're still hell-holes," says Weingust, explaining the Kowalskis' refusal to accept the Ministry's alternatives. He believes the reason it is proving so difficult to get Kowalski out of the penal system is that the Ontario government is unwilling to admit that "they've made a terrible mistake."

"They've never been able to tell us what the problem is in transferring him. He has no record of violent behaviour, and has never committed a violent crime, but now they're calling him dangerous."

Weingust believes that Kowalski has been given most of his 63 shock treatments since he has been in Penetanguishene, and feels that the fact that the Kowalskis can't speak English has played a large part in the drama.

"I have another client whose son was in Lakeshore. They were the same kind of people (non-English-speaking) in the same type of situation."

He also thinks that a number of other people may be suffering the same fate as the now 29-year-old Kowalski; but the government won't reveal the names or numbers of people they transferred to Penetanguishene when

Queen Street was being rebuilt or when Lakeshore Psychiatric Hospital was closed down.

If the Kowalskis are unsuccessful in trying to appeal the decision, they may attempt to sue the government if they can prove their son has suffered irreparable damage. In the meantime, Weingust doubts that Henry will ever be able to function in the outside world again.

# MD links Valium with cancer growth

A Montréal doctor has been fired from his job with the Clinical Research Institute because he stated publicly that his research showed that diazepam (Valium) might make human cancers grow faster.

Dr. David Horrobin said he was not suggesting that the drug actually *caused* cancer, but rather that when it was given to someone suffering from cancer it might cause the tumor to spread more quickly.

A British researcher, Dr. Basil Stoll, had found that women with breast cancer were more likely to have it spread beyond the breast if they had taken tranquillizers. He interpreted this as a sign that high anxiety levels (for which tranquillizers would be prescribed) affected the growth of the cancer.

But Dr. Horrobin's work indicates that the more rapid growth may result from the drug itself, rather than from the higher anxiety levels.

Dr. Ian Henderson, director of the bureau of drugs in the Health Protection Branch of the federal government, says that Dr. Horrobin's work should be taken seriously, and that he would like further information on the possible connection.

The Institute apparently asked for Dr. Horrobin's resignation because he broke an Institute rule against speaking to the media without the director's permission, and because another laboratory at the Institute had been unable to duplicate his animal tests of Valium, in which cancerous rats treated with the drug developed tumors three times as large as those not treated.

# Death at Millhaven

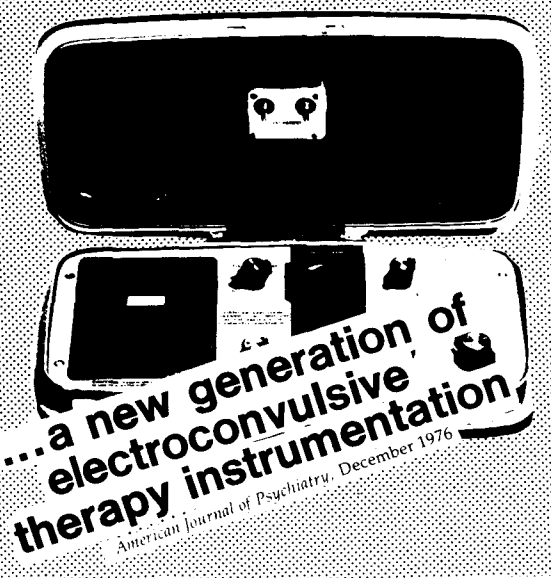
A Brantford family has blamed prison authorities and repeated shock therapy as contributors to the stabbing death of 30-year-old Henry MacDonald on November 24, 1980.

MacDonald died in a Kingston area penitentiary where he was sent last fall after breaking parole to visit his family. He was staying at a halfway house in London, and was also receiving therapy at London Psychiatric Hospital.

"They should never have sent him back to prison," his brother Bruce told a Toronto *Sun* reporter. "He was sick and needed help. Sending him back to prison was like sending a seven-year-old in there."

His brother said MacDonald hadn't been the same since receiving shock therapy at Millhaven Penitentiary eight years earlier. He added that during a summer fishing trip his brother became hysterical when he started the boat motor because he thought "it sounded a lot like the machine they used during the electro-shock therapy."

"They burnt him out. He had the IQ of a two-year-old once they were finished with him. All he wanted to do was come home. He was told to report to the parole officer, but he couldn't take on that kind of responsibility in his condition."




According to prison authorities, MacDonald had spent the last four years in prison for breaking parole.

# Queen Street's open door policy

The "open door" policy of Queen Street Mental Health Centre has come under fire since the death of Fortunato Mactal, 22, who walked out of the centre in his pajamas and threw himself off the Bloor Street Viaduct.

The doors were "opened", even though many inmates still have to wear pajamas, when drugs became the usual method of treating inmates, says Queen Street spokesman Ray Havelock.

Havelock told reporters that a dozen inmates a year die, in the hospital or during out-patient follow-up care, because of this policy, and said that Mactal and Aldo Alviani

were just two "terribly unfortunate" examples.

But, says Havelock, "People are so afraid of this place that when a family really needs help they're afraid to come here. Padlocks would only make it worse."

Only about eight per cent of Queen Street's inmates inhabit wards with locks on the doors. Penetanguishene's Oak Ridge facility for the "criminally insane" houses the largest number of locked-up inmates in the province--298--and only those who are considered dangerous to society.

# Two shock victims get damages

An inmate treated with electroshock therapy without his consent has settled out of court with the Canadian Medical Protective Association.

According to the CMPA's 79th Annual Report, issued in September 1980, the evidence indicated that the inmate believed he was to have "tests". After one treatment, he angrily transferred to another hospital, and filed suit against the doctor for assault and battery.

Although there was no evidence that he had been harmed, "it was the Association's conclusion that a successful defence would not be possible because of lack of consent".

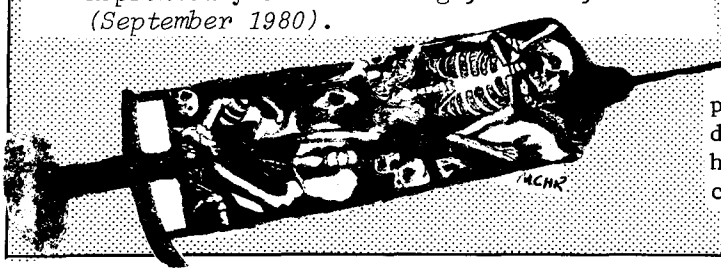
●●●●●●●●

In late 1979 the case of *Angelo v. Mamouris* was heard in New York State's Superior Court. The parents of Soteria Angelo, a young woman born with slight brain damage and a mild form of epilepsy, had several years earlier sought psychiatric help for their daughter from Dr. Constant Mamouris, who was affiliated with Gracie Square Hospital in NYC.

Two weeks after Ms. Angelo's first visit with Mamouris, he began administering to her a series of 12 electroconvulsive treatments. These were followed by numerous "maintenance" electroshocks over a three-year period. All told Angelo was subjected to 90 ECTs.

The suit charged that these treatments gravely aggravated her epilepsy and caused her to lose her acquired secretarial skills, making it impossible for her to resume her previous employment. Several days into the trial, Angelo accepted Mamouris's offer of $150,000 damages in settlement.

--*Reprinted from* On The Edge, *vol. 1, no. 5 (September 1980).*



# Ontario Human Rights-one step closer

It looks as if the Ontario government is about to give people with physical or psychological handicaps some long-overdue human rights protection against discriminatory practices in recently proposed amendments to Ontario's *Human Rights Code*. (Ontario, Alberta and Newfoundland are the only provinces which still deny handicapped citizens legal protection against discrimination in access to or use of public services and facilities, housing and employment.)

On November 25, Labout Minister Robert Elgie finally introduced in the Legislature a bill titled "An Act to Revise and Extend Protection of Human Rights in Ontario". A key feature of the bill is the broadening of the *Code*'s prohibited grounds of discrimination to include the handicapped. It also bans discrimination on the basis of age for people aged 18 to 65 (why not from birth to death?) and people receiving public assistance (welfare, family benefits, and government pensions).

In the bill, a handicapped person is specifically and broadly defined as a person who

> *has or has had, or is believed to have or have had*
> *(i) any degree of physical disability, infirmity, malformation, disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, including epilepsy, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a dog guide or on a wheelchair or other remedial appliance or device,*
> *(ii) a condition of mental retardation or impairment,*
> *(iii) a learning disability, or a dysfunction in one or more of the processes involved in understanding symbols or spoken language, or*
> *(iv) a mental disorder ... .*

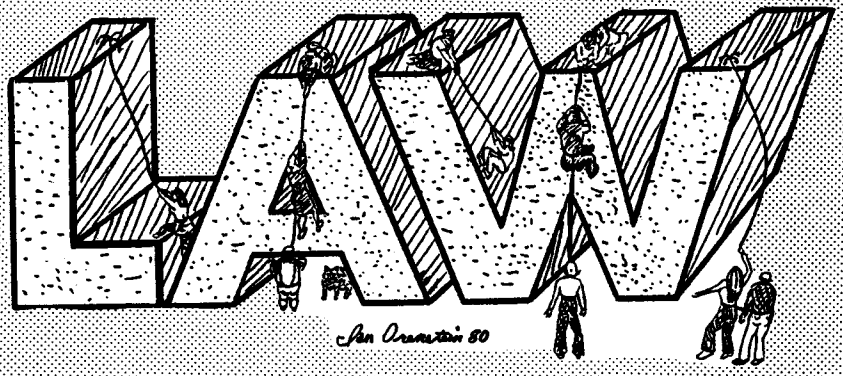
As a result of this broadened definition, people with any such handicap cannot legally be denied access to any public service or facility housing, or employment because of their handicap.

The bill also specifically bans sexual harassment, an issue of obvious and immediate concern to women. The relevant section reads:

> *Every person has a right to be free from*
> *(a) a persistent sexual solicitation or advance made by a person in authority who knows or ought reasonably to know that it is unwelcome; or*
> *(b) a reprisal or a threat of reprisal by a person in a position of authority for the rejection of a sexual solicitation or advance.*

To its credit, the government appears concerned enough about sexist practices and attitudes to begin cracking down on those male chauvinist bosses who can't keep their hands off some of their secretaries and other female employees.

The bill also gives more clout to the enforcement powers of the Ontario Human Rights Commission. For example, any person or organization which violates any part of the *Code* can be fined as much as $25,000. For example, an employer who refuses to hire a person because of present or previous psychiatric treatment can be fined--and it's about time. The Commission is also made more accountable to the public; it must reach a decision within 30 days after a complaint of discrimination has been filed.




The Coalition for Human Rights for the Handicapped, which has pressured the government during the last nine months to change the *Human Rights Code* to protect handicapped people, generally supports this bill. (See vol. 1, nos. 1 and 2 of PHOENIX RISING for more information on the Coalition and the rights struggle.) However, the bill still does not guarantee handicapped people the right to be covered by an insurance or pension plan. In a press release on November 26, the Coalition stated:

> *The primary areas of concern include reasonable accommodation to overcome barriers faced by handicapped people and the fair opportunity to participate in insurance and pension plans.*

(See our Opinion section for more on ex-psychiatric inmates and insurance.)

Since 1981 is the International Year of Disabled Persons and the time of another provincial election, we have reason to believe that the Ontario government will pass this crucial piece of human rights legislation, perhaps this January or February. And when it does, the members of the Coalition--over 70 groups of and for handicapped people (including ON OUR OWN)--can rightly congratulate themselves for struggling together and using their great collective power to move the traditionally unmoveable Ontario government.

# They always get their "manic"

During the past 10 or 11 years, the RCMP (like the FBI and CIA) has committed many serious crimes in its continuing efforts to disrupt radical or leftist groups, the NDP, and the labout movement in Canada. "Operation Tent Peg" (1969-71), "Operation Oddball" (1971-72), and "Operation Checkmate" have all involved the RCMP in numerous illegal and unethical activities.

These capers have recently come to light as a result of three investigations by government-appointed bodies: the McDonald Commission the Keable Commission, and, most recently, the Krever Commission in Ontario. (The next issue of PHOENIX RISING will examine the just-published Krever Report on confidentiality of health information, and its implications for psychiatric and former psychiatric inmates.)

RCMP dirty tricks have included threatened bodily injury or assault; forced illegal entry; stealing the membership files and/or financial records of the Parti Québecois in Québec and the Praxis Corporation in Ontario; receipt and/or seizure of confidential medical information from OHIP in Ontario; and falsifying and distributing libellous material.

On at least one occasion, the RCMP has used a Canadian's psychiatric history to discredit him and disrupt a political organization. In September 1972, the force concocted

a slanderous letter about the leader of the Toronto-based Young Socialists organization, who had had psychiatric treatment a number of years earlier. The RCMP lied to the McDonald Commission in 1978, denying their knowledge and authorship of this letter, but then admitted it before the Krever Commission hearings in 1979.

The following unsigned letter was sent to the leader's home in 1972 (the full text appears in the Krever Report, vol. 2):

> *Comrade:*
> *We have been most disturbed lately by indications of increased instability on your part, witnessed by psychiatric consultations, verbal outbursts of temper and frequent periods of irritability. ... Your condition has not escaped the notice of others. ... While a certain amount of nervous strain is natural, we do not feel that your recent behaviour is consistent with one who is capable of maintaining a responsible, sound leadership over our movement. ... We encourage you to lay bare the truth about your condition before the membership at the forthcoming YS conference.*

The letter ends on a note of threatened blackmail:

> *Should you fail to take this opportunity ... you must be warned that we will consider it our duty to inform comrades of the situation, an act which would not be extremely palatable to either party concerned.*

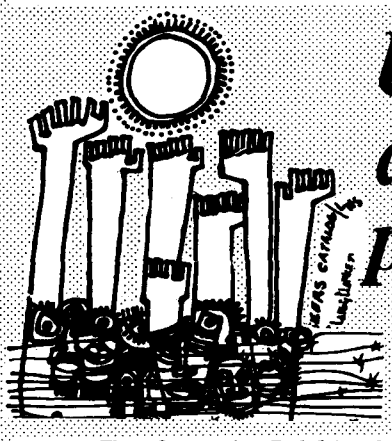
This letter and similar ones were secretly distributed at conferences and meetings of the Young Socialists.

After learning of such RCMP letters, and of the RCMP's illegal access to and use of Canadians' health records, Mr. Justice Krever rightly expressed his distrust of the RCMP and other police forces with respect to their alleged right of access to citizens' health information. In his report, Mr. Justice Krever writes:

> *With respect to the RCMP, however, a force not accountable to provincial authorities, one cannot remain confident that OHIP information will not be used for such purposes as health information was used for in the (leader's last name) affair. ... I do not believe that the use of confidential information for this or similar purposes is acceptable to members of Ontario society. ... If confidential health information were to be made available to the RCMP from OHIP records, even in a limited fashion, could there be any safeguard against its use for disruptive purposes?*

To date, no RCMP officer has been charged with any crime, despite damning RCMP admissions, lies and cover-ups during the various Commission hearings.

*(For more on this incident and other RCMP dirty tricks, see* In The Federal Court--Between: Dowson v. RCMP *(Forward Publications 1980), available for $3.95 at Forward Books, 121 Church St., Toronto.)*



# Union attacks psychiatric system

The Ontario Public Service Employees Union (OPSEU), like any union, is naturally concerned about keeping jobs, raising wages, and improving working conditions for its members. It is this pro-union perspective which informs OPSEU's damning critique of Ontario's "mental health" non-system, *Ontario's Mental Health Care Breakdown*.

This fact-filled, well-researched booklet came out about a year ago after Lakeshore Psychiatric Hospital and a few other psychiatric institutions closed, causing layoffs of many of OPSEU's civil service workers. Unnecessary layoffs, unreasonable cutbacks, and a conspicuous lack of planning and coordination of psychiatric services and facilities by the Ministry of Health are the main targets of OPSEU's attack. The tone is one of righteous anger.

However, OPSEU is conspicuously silent about such known psychiatric abuses as staff brutality and mistreatment of psychiatric inmates and "mentally retarded" people; massive forced drugging of inmates; electric shock treatment; staff infantilization of inmates (especially the elderly and the "retarded"); behaviour modification; and inmates' lack of civil rights.

Perhaps it's too much to expect OPSEU to attack "treatment" in the psychiatric institutions where many of its members work as nurses attendants, social workers and psychologists. And perhaps it's too much to expect OPSEU to question or challenge the myth of "mental illness" and the many other myths and biases endemic to the non-system. Members could lose their jobs for daring to speak out. The battle against institutional psychiatry must be waged chiefly by inmates and former inmates. OPSEU's "mental health" workers are welcome to help in this struggle, providing they join us as *equals*.

# IN BRIEF

The proposed amendments to the Ontario Human Rights Code (see elsewhere in this section) may put an end to the type of questions a Kitchener company has been asking its prospective employees.

Female applicants are asked to answer more than 150 intimate questions about their sex lives and menstrual history. Both men and women are required to answer questions about their consumption of alcohol, and about psychiatric histories of themselves and their families, in order to get jobs at Canadian Blower Canada Pumps Ltd.

J.R. Adare, president of the company, which employs 395 people and manufactures fans, air conditioners and centrifugal pumps, claims that any information on the applications is kept confidential between the company doctor and the applicant.

Women for Justice has filed a sexual discrimination complaint with the federal Human Rights Commission over the lack of services available to women in prison.

Along with complaints about the vocational and educational opportunities available (hairdressing is the *only* accredited course for women), the brief noted that in the Kingston Prison for Women, the only maximum security prison for women in Canada, psychiatric and medical services are inadequate. Inmates must wait long periods of time before they can see doctors or be admitted to hospital, despite the fact that they need more medical attention than men.

A psychiatrist from the Clarke Institute of Psychiatry who testified at the trial of an Ontario man convicted of molesting neighbourhood children was given a verbal rap on the knuckles last fall by presiding Judge Kenneth Langdon.

Judge Langdon disagreed with the testimony of Dr. Basil Orchard, who contended that the man's tendency to molest children was "a direct result of depression".

"That flies in the face of logic," said Judge Langdon. "Thirty per cent of the population suffer from depression but don't go around molesting children. The courts must scrupulously guard against abdicating their function to medicine."

A Toronto doctor has been reprimanded by the College of Physicians and Surgeons of Ontario for giving a two-and-a-half-year-old child 27 types of drugs, both singly and in combination, for alleged hyperactivity.

Dr. Thomas Nicholas, who restricts his practice to people with learning disabilities and speech defects, gave the child doses at the upper limits of the adult range.

A Toronto physician has been fined $20,000 for charging OHIP for psychiatric treatments he never gave patients in 1976 and 1977.

County Court Judge Arthur Whealy has put Dr. John Alexander Orpin on two years' probation and ordered him to pay the fine at $420 a month.

# Rights and Wrongs

## WRONGFUL STERILIZATION

by *David Baker*

When is a sterilization illegal? There is no legislation in the province of Ontario which deals specifically with a medically unnecessary sterilization of a person without his or her consent (or the consent of someone else where the person does not have the legal capacity to give or withhold consent).

The section of *The Mental Health Act* and the regulation under *The Public Hospitals Act* dealing with consent are both concerned with "treatment". It appears to be well-established that a medical procedure carried out for non-medical reasons cannot be considered to be "treatment". Nevertheless, the courts may have a difficult time deciding what is a "therapeutic" as opposed to a "non-therapeutic" proce-

dure. For example, doctors have received legal opinions that a sterilization carried out primarily for birth control, and secondarily for relief of menstrual cramps, is therapeutic, even though they acknowledge that the procedure

EUGENE

by *Philip Giglio*

Eugene laughs
his big broad smile
twinkling eyes
occupy that space
closest to you
some people don't like his eyes

Eugene paints
long dark tunnels
colour filled stars
Eugene makes clay ashtrays
this boat ashtray has three smokestacks
he invites each new person into our room

Eugene tries
"wanna buy a painting?"
"wanna buy an ashtray?"
Eugene begs
"aw c'mon
I'd like a new canvas"

Eugene plays chess
he wants to play three dimensional chess
he can't go out you know
so if you ever go in
enjoy his laughter
some people think it's like crying

would never be performed on a non-handicapped woman in similar circumstances.

The doctor is the one who makes the first decision. He is absolutely liable if he is wrong; therefore, he would be wise to seek a legal opinion if there is any uncertainty on this point. A person representing the interests of a handicapped person should encourage the doctor to have a court decide whether the operation is in fact "therapeutic".

Another issue originally left to the doctor is that of whether the person is legally capable of consenting to the operation. This means that the person is able to understand the nature of the operation, and able to appreciate the consequences of giving or withholding consent. In practice, a person willing to consent is probably more likely to be judged competent than one who refuses.

Because sterilization is usually not reversible, there are powerful arguments for reforming the law in this area, especially for having a compulsory review before any sterilization is performed.

* * *

In the case of a non-therapeutic sterilization of an incompetent person, there is no legislation to refer to. We must therefore consult what is known as the "common law"--principles established by court decisions over the years.

The right to have children has been recognized in Canadian law as a fundamental liberty. Similarly, the right to have a non-therapeutic sterilization has been established *when the operation is for the benefit of the plaintiff*. In some American decisions, the court has authorized sterilization for the benefit of the family, the unborn child, or the state. In law, only the interests of the person to be sterilized are to be considered.

This, however, does not end the matter. The person himself or herself may have conflicting interests. One might argue that it would be to a person's benefit to be sterilized if, for example, he or she were unable to use contraceptive methods effectively, or was likely to suffer emotionally from a pregnancy and birth, or was incapable of being an effective parent to a child. A court would have to weigh these arguments against that of the fundamental right to have children.

* * *

If someone is faced with the prospect of being sterilized without consent, there are a number of possible courses of action.

(1) Contact the Ministry of Health. The Ministry has been unwilling to state an "official position" on involuntary sterilization. However, it will apparently intervene to enforce the moratorium it imposed in the case of people under the age of 16. If the facts of the case do not become clear until *after* a sterilization has taken place, in the case of a person under 16, the Ministry may help in lodging a prosecution.

(2) Contact the Children's Aid Society. Again, this applies only to persons under 16. An illegal sterilization is a battery, and clearly qualifies as an abuse. Where a charge of abuse is made, the Society has an obligation to investigate and, if necessary, remove the child to a "place of safety" until the matter is determined by a court.

(3) Contact the Official Guardian's Office. Mr. Lloyd Perry, Ontario's Official Guardian, has expressed his willingness to intervene in these cases, whether or not the person is a minor. The prestige of his office might well induce those seeking the sterilization to refer the matter to a court for determination. However, it is not yet clear that the Official Guardian has any real authority in this area, so this recourse should probably be used only in conjunction with other steps.

(4) Inform the police. As has been stated above, an illegal sterilization is a

battery, which is both a criminal and a civil matter. The police should therefore be prepared to intervene. However, it is unlikely that a policeman will be familiar with this sort of matter, and even less likely that he will be prepared to interfere with a doctor armed with a legal opinion from a prestigious law firm.

These four suggestions are all of informal remedies which do not require participation in a hearing before a court. However, if they fail there are other, more formal, remedies available to you.

(5) Wardship. The courts have the power and the responsibility of safeguarding the best interests of a minor or a mentally incompetent person. They should be willing to hear an argument that, because of the decision made about sterilization, the present guardian is not safeguarding the best interests of the person involved, and that the person should be made a ward of the court. This would not mean that the person would have to be removed from the care of parents or present guardians--only that no important decision about the person's life could be made without the consent of the court.

(6) Injunction. If time is pressing, and the guardian and the doctor are so determined that they would not be stopped by an application for wardship, the alternative is to apply for an injunction. It is likely that the court would immediately issue an interim injunction, forbidding anyone from carrying out the procedure until there could be a trial as to whether the proposed sterilization was legal.

(7) Guardianship. In extreme cases, where continued contact with the parent or guardian is seen as undesirable, the court might consider an application from someone else for guardianship, based on but not limited to the question of the proposed sterilization.

(8) Damages. Once a sterilization has been performed, what has done cannot be undone. No amount of money can compensate a person for the violation of his or her personal integrity. However, some compensation may be gained from a suit for damages. Parents may be surprised to know that they, as well as the doctor, can be found liable for an illegal sterilization, since by authorizing the procedure they have breached their duty as guardians; they can be charged as a result of a 1978 Ontario statute, *The Family Law Reform Act*, which enables children to sue their parents. Even a court which has authorized a sterilization in the clear absence of jurisdiction to do so can be found liable for damages.

* * *

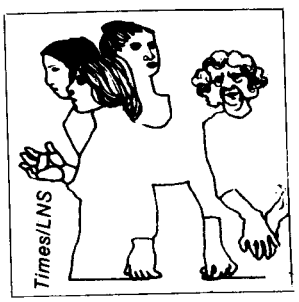
The remedies listed above have not yet been invoked in Ontario. However, a number of recent developments have for the first time given some legal muscle to the civil rights aspirations of people labelled "mentally retarded" or "mentally ill". As a result, the situation is bound to change.

However, mere enforcement of present laws is not enough. The law itself is mired in nineteenth century assumptions about "handicapped" people, and only new legislation can resolve the problems arising in this very difficult area.

*David Baker is a Toronto lawyer.*

# the Book-Worm Turns

Women & Madness, by Phyllis Chesler. New York: Avon Books, 1972. 360 pages, paper $2.50.




Reviewed by *Carla McKague*

It is eight years since Women & Madness was first published. The growth of feminism over that period means that a reader coming to Chesler's book is in for fewer surprises than one who read it in 1972. We know a lot more than we did about "male chauvinism", "sex stereotyping", and the other rallying calls of the women's movement. And, consequently, we are more prepared to accept Chesler's thesis--that the "mental health" establishment, dominated by white middle-class males, has engaged in a systematic oppression of women.

That this is less of a surprise to us makes the book no less valuable. Chesler's book is a *tour de force*, ranging from mythology and history through vivid personal accounts from sufferers to statistical data--all demonstrating her thesis beyond any doubt.

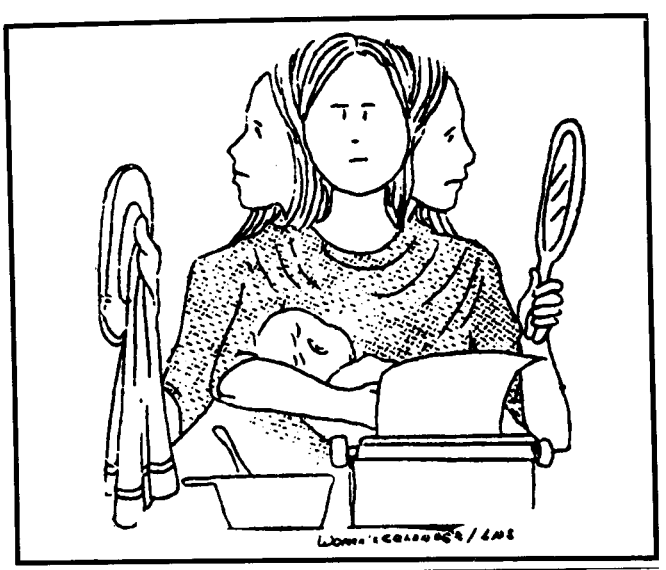
She examines in detail the special problems of some female subcultures (lesbians, Third World women and feminists), and devotes an entire section of the book to women who have been sexually exploited by male therapists.

For me, the most revealing parts of the book were those in which Chesler presented women's first-hand accounts of their devaluation and degradation by the "system", both institutional and non-institutional. The women she talked to were painfully and revealingly articulate. Take Sheila, for example, one of the women who became sexually involved with their therapists:

> *He told me I was blocked, that there were things I had to work out with my father, and that maybe we could solve it on a non-verbal level if I would just trust him ... and that I was going to have to trust him. So maybe he's bizarre and unattractive--I didn't feel too straight myself. ... Oh, God. Then he got up, dropped his pants, said, "Take your pants down," or something really insensitive, unsensual, and he just got on top of me. He came, I didn't come. And then I said, "I'd like to get on top of you." And then he told me that that was my problem, that I wanted to be in control ... .*

Or Donna, a feminist with a male therapist:

> *"Why don't you fix yourself up?" he always said. "You look like a hobo--I'd almost think you were afraid of men!" Not a word about how right we are to be afraid. Not a word about athletics, lesbianism, poli-*



*tics or my eternal soul. Just "Dress up for Daddy" as proof of mental health.*

Or Laura and Joyce, who encountered the institutional version of this attitude:

*Fix yourself up, they told me. So every morning I got the hot sweats (insulin therapy) and every afternoon I spent in the beauty parlor with the other women.*

*I had a doctor who kept interviewing me. ... I remember I was looking terrible, my hair wasn't combed, I had no make-up. He said, "Why don't you fix yourself up? A nice girl like you!" And I said, "I never want another man to look at me again."*

Chesler takes these experiences and her data, and comes up at the end of the book not with answers, but with questions. And the questions, alas, are as unanswered as they were in 1972. Those eight years may have raised our collective consciousness about sexism, but they haven't brought us much closer to finding truly loving and egalitarian ways for men and women to deal with one another.

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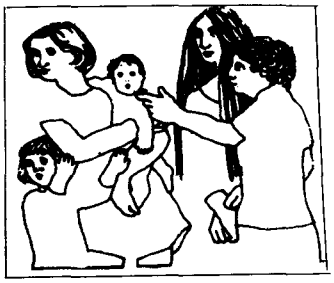
Women Look at Psychiatry, edited by Dorothy E. Smith and Sara J. David. Vancouver: Press Gang, 1975. 199 pages, paper $4.50.



Reviewed by *Don Weitz*

Female psychiatric inmates are doubly oppressed--as women and as psychiatric inmates. Awareness and power are the core concepts which women must use to break out of the old sexist stereotypes and overcome all forms of oppression, particularly psychiatric oppression, so that self-liberation will become a reality, not illusion.

This is the sort of awareness which informs Smith and David's Women Look at Psychiatry. This book is, I believe, the first anti-psychiatric work in Canada written and edited from a feminist perspective; it's a fitting companion to Phyllis Chesler's Women and Madness (also reviewed in this issue).

The book is a fairly diverse but unified collection of fourteen writings by eleven Canadian women from British Columbia. At least half the contributors are professionals; four are ex-psychiatric inmates. But all share and advocate a feminist approach to women's problems and to life.

Being an ex-psychiatric inmate, I particularly like some of the more personal statements by other ex-inmates such as Judi Chamberlin (author of the critically successful On Our Own and a fighter in the Mental Patients' Liberation Movement) and Barbara Joyce.

Judi painfully but beautifully describes some of her many battles and panic attacks with institutional psychiatry in "Struggling To Be Born". Fortunately, she escaped shock treatment, but was typically over-drugged, as are most women in male-dominated "mental hospitals". Years after her release from Rockland State Hospital in New York, Judi went deep into herself, mainly because of the pain and damage she experienced in these psychiatric prisons. She writes:

*It would be years before I would once again risk the struggle of being born.*

After some enlightening but sometimes too theoretical articles on feminist therapy and therapists, the book ends with another outstanding autobiographical piece by Barbara Joyce. In "I'm Not Crazy After All", Joyce sharply contrasts the traditional professional and feminist approaches; as expected, she comes out strong for the feminist approach, which enabled her to attack some of her real problems, be taken seriously, and become a freer and whole person.

Male-dominated psychiatry--particularly the sexist, paternalistic and manipulative attitudes and practices of all too many psychiatrists--is justifiably exposed as destructive to women's struggles to be themselves. In their feminist critique of psychiatry, Smith and David help to expose the blatant sexism in psychiatry and in the "mental health" system generally. They have issued a direct challenge to women to confront and fight against all forms of psychiatric oppression and control their own bodies and minds. The book's subtitle is most appropriate: "I'm Not Mad, I'm Angry".

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Shadowland, by William Arnold. New York: McGraw Hill, 1978. 260 pages, $11.95.

Reviewed by *Cathy McPherson*

Picture a woman in her early twenties, an advocate of human rights and a supporter of liberal causes. She is arrested one day for driving without a licence in her purse, denied her legal rights at the police station, and eventually committed against her will to a psychiatric institution with conditions reminiscent of a Nazi concentration camp.

For the next few years this woman is subjected to electric shocks, overdosed with insulin, injected with experimental drugs, raped repeatedly by soldiers from a nearby army camp, and finally, it appears, given a prefrontal lobotomy.

* * *

For those of us used to thinking of imprisonment, torture and brainwashing as something that goes on behind the Iron Curtain, this scenario, taken from the life of American Frances Farmer, may come as somewhat of a shock.

Farmer's story has always been a bit of a mystery to those who knew her as a glamorous Hollywood star who rose to prominence in the late 1930s, and then dropped out of sight in 1942.

Shadowland sets to rest most of the strange rumours and half-truths surrounding this woman, thanks to a persistent three-year investigation by author William Arnold, and reveals in their place a truly horrifying chapter in American history.

Farmer had the misfortune to be born the youngest daughter of a domineering mother in the city of Seattle. While Mrs. Farmer might have seemed eccentric to some, her patriotic, anti-labour, anti-Communist sentiments jived

strongly with the attitudes of most people in the State of Washington, and indeed in the nation itself.

In short order, Frances managed to step on everyone's toes with her forthrightness and incredible knack for getting involved in causes that would alienate her mother and others of her ilk.

At age 16, Frances won a national writing award for an essay questioning the existence of God. After the furor died down, she made a name for herself again when, as a successful acting student at the University of Washington, she opposed a vigilante movement of prominent citizens intent on stopping the "Communist conspiracy in the northwest" by burning books, arresting people, and busting heads.

The incident became etched in Seattle minds when Frances won a trip to Russia by selling the most subscriptions to a Communist publication which opposed the vigilante movement. Although Frances was never a Communist herself, she was branded from this point on.

No sooner had Frances returned from Russia than she was "discovered" by Hollywood. But she soon fell into disfavour among Hollywood personalities for her ridicule of Hollywood productions and society life.

She embraced the stage instead, and poured most of her money into improving the lot of migrant California farm workers and supporting the Loyalist cause during the Spanish Civil War.

While the actress may have been emotionally shaken over the breakup of her marriage at this time, Arnold provides sufficient evidence to prove that she was never "mentally ill"--only unlucky.

I doubt whether anyone, least of all Frances herself, could have predicted the serious consequences of her actions. When a prominent psychiatrist personally intervened in the court case over her licence to have her committed (because he thought she was "manic depressive"), Frances just couldn't take it seriously.

Mrs. Farmer, however, was easily convinced that commitment would be best for her daughter; after all, Frances's attitudes and opinions had always run contrary to what she considered "normal".

In a move that ruled out any kind of normal life for Frances again, Mrs. Farmer gained guardianship of her daughter, and thereafter had her committed whenever she didn't do things her mother's way.

During the years of her exile in hospital, Frances never accepted that she was "sick". What began as a point of pride ended up being classified as "schizophrenic" and "paranoid" behaviour by psychiatrists who in turn grew more zealous in their attempts to break the will of this stubborn woman.

Although all of Arnold's evidence points to the conclusion that Frances finally received an experimental lobotomy, doctors would have had to do it against the wishes of her parents, who were, surprisingly, opposed to it. Since the letter of the law seems to have been ignored in the rest of Frances's treatment, however, such an operation cannot be ruled out as unlikely. Certainly from all accounts Frances was a different woman from this point on.

It's too bad that Arnold doesn't provide us with a complete list of all the psychiatrists and their followers who were responsible for torturing Frances and other human beings in her hospital in the name of "mental health". Many of these people are still alive, still prominent, still espousing their brilliant theories, and still directing therapeutic programs in the United States and in Canada. They just don't want to talk about the Frances Farmer case any more.

Now that's something to think about.

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Will There Really Be a Morning?, by Frances Farmer. New York: Dell Publishing, 1972.

379 pages, $2.50 paper.

Reviewed by *Cathy McPherson*

Will There Really Be a Morning? is a gripping rendition of Frances Farmer's life, as told to ghost-writer Lois Kibee and rewritten by Jean Ratcliffe, Farmer's roommate in her later years. But, after being told by William Arnold in Shadowland that several scenes near the end have apparently been sensationalized by Ratcliffe or fabricated to glorify herself, one can't help wondering whether it all really happened.

Will There Really Be a Morning? has little of the political background and hard reporting found in Shadowland, but does provide an interesting perspective when read along with that book, particularly if you know of Ratcliffe's attempt to re-tell the story. I was convinced that some of it really did happen, particularly the events talked about early in the book, but predictably there is no mention of the possibility that Farmer might have had a lobotomy.

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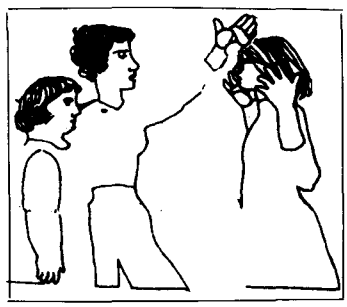
About Men, by Phyllis Chesler. Toronto: Bantam Books, 1980. 290 pages, paper $3.95.



Reviewed by *Bill Lewis*

Phyllis Chesler, in her book About Men. refers to "some men" who are tender, affectionate, and sensitive to the needs and feelings of others. It's been my experience that this sensitivity comes from being in touch with our own feelings and being confident enough in our own *personhood* to be open, vulnerable and receptive to our friends and loved ones.

In the struggle against sexist ideas and actions, no man has a perfect scorecard. However, I do feel that those who are aware of how sexism limits their relationships with others, and act upon it, are important examples in this time of personal and social change. It's too bad that such examples are invisible in Ms. Chesler's book.

There are tantalizing references to "some men", but not one specific example is expanded on--nor is there any analysis of how these people managed to overcome all the barriers to humanity that she documents so well. If her purpose, as she says in writing this book, is to understand man, then I believe this is a serious omission.

As much as I was looking forward to it, I had a hard time reviewing this book, because I'm essentially optimistic--not about the mass, but about the growing minority of groups and individuals that are the seed for the flowering of humanity in the future. Personal growth and social change should not be an unpopularity contest, where one counts heads and then eliminates the minority from consideration. Those who resist the prevailing ideology and rebel against the existing institutions are where we must look to find a road map to social revolution. Knowing why people revolt is more important than just documenting what exists. Without learning what we can be and how to get there, just knowing our past impulses and present motives is not enough to effect real change.

Ms. Chesler makes the male psychology and personality sound like a genetic terminal illness. Nowhere, not even in the "some men" she speaks of, is there any hope for the future.

I really get lost sometimes with her psychoanalytical and mythical references. I just can't identify with many of the things she takes so much for granted. I'm afraid her training as a psychologist was responsible for much of the script here.

I spent most of my early years in orphanages and prisons. In that context I would ask Ms. Chesler why we don't have the victim's viewpoint of what prison rape means to her or him. A young man subjected to the violence and sexism of the prison system can identify with sisters out here in the minimum security prison we call the "free world" who live with the horror of rape. We can see how it's rooted in power, not sex, when even consensual gay acts are accompanied by violence and the butch/femme role-playing. In some ways rape in prison is an even more traumatic experience because of the closed environment where it has to be lived with daily and where there's no way out.

I was really struck by how she took a series of paintings and sculptures and in some instances gave a brilliant insight and in other places would read in what wasn't there. If Sylvia Sleigh's painting (p. 110) of a graceful young male were in a gay publication full of photos of young boys, it would be considered exploitive. Her descriptions of "masculine/feminine" characteristics in art were confusing to me. One gets the impression androgyny doesn't exist in the human makeup, and we are either all male or all female.

Chesler also contradicts herself when she

uses fables and mythology to make her point, but denies us the right to use "fairy tales" to shape our future.

As strongly as I feel about what's missing from her book, there are valuable insights that should not be missed. We should welcome what she calls The Autumn of Patriarchy, but let us also cheer the arrival of the Goddess of Spring.

ANNOTATED ANTIPSYCHIATRY BIBLIOGRAPHY (FOURTH INSTALLMENT). Prepared by *Cathy McPherson*.

Barnes, Mary and Berke, Joseph. *Mary Barnes: Two Accounts of a Journey Through Madness.* Harmondsworth: Penguin Books (1973), paper $2.50. Fascinating parallel accounts by a woman and her therapist of the controversial treatment for "schizophrenia" initiated by psychiatrist R.D. Laing at Kingsley Hall in England.

Bodnar, Ana and Reimer, Marilee. *The Organization of Social Services and its Implications for the Mental Health of Immigrant Women.* Toronto: Working Women Community Centre (1979), paper $6.00. This 126-page study of the "accessibility and relevance of (Toronto) social services to immigrant women" experiencing psychiatric problems finds a "wide gulf between the established social and health care services and the needs ... ." The community centres to which these women prefer to go for help consider that their problems are emotional or cultural rather than the result of social situations.

Friedman, Susan Stanford. *A Women's Guide to Therapy.* Englewood Cliffs: Prentice-Hall (1979), paper $4.95. This excellent American book encourages women to pursue a "consumer" approach to selecting the best therapist for their needs, and suggests ways and means of evaluating therapists, with a chapter on women and mental institutions. Easy to understand and well worth reading.

Gordon, Barbara. *I'm Dancing As Fast As I Can.* New York: Harper & Row (1979), $11.95, paper $2.75. A moving autobiographical account of a gifted woman's struggle to overcome Valium addiction and re-establish herself after her subsequent breakdown. (See full review in PHOENIX RISING, *vol. 1, no. 1.*)

Hughes, Richard and Brewin, Robert. *The Tranquilizing of America: Pill Popping and the American Way of Life.* New York: Warner Books (1979), paper $2.95. A brilliant exposé of the overuse of tranquillizers in America, with chapters on the pacification of women, children and the elderly. (The chapter on women cites the work of Ruth Cooperstock of Toronto's Addiction Research Foundation, whose column on Valium appeared in PHOENIX RISING, *vol. 1, no. 1.*)

Kaufman, Gloria and Blakely, Mary Kay. *Pulling Our Own Strings.* Bloomington: Indiana University Press (1980), paper $9.95. A funny, bittersweet collection of humorous writing, cartoons and satire by feminists, including a chapter titled "For All the Crazy Ladies" which contains "No One Has a Corner on Depression but Housewives are Working On It", "I'm Sorry, You're Sorry", "AAAAAAAAAARGH", and more.

Long, James W. *The Essential Guide to Prescription Drugs.* New York: Harper & Row (1980), paper $11.75. If you have problems understanding the *Compendium of Pharmaceuticals and Specialties* or can't afford to buy it, this book is for you. It deals with safe use of both prescription and over-the-counter drugs in simple, easy-to-understand language, and includes Canadian brand names of drugs. It also talks about side effects to watch for, when to take drugs, what not to take them with, and so on.

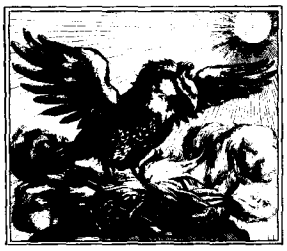
Miller, Jean Baker. *Toward a New Psychology of Women.* Boston: Beacon Press (1979), paper $4.95. Says all the "right" feminist things about therapy, but in a fairly complex way. Requires some education and persistence to get through.

Rush, Anne Kent. *Getting Clear.* New York: Random House (1973), paper $8.95. Through dialogue (in most cases between women) and exercises that both women and men can do, this book deals with the mind/body relationship in the emotional makeup of women. A fun, hippy-dippy book to read, and an expanded form of *Feminism as Therapy* Random House 1974) by the same author and Anica Mander.

Wyckoff, Hogie. *Solving Problems Together.* New York: Grove Press (1980), $9.95. (Originally published as *Solving Women's Problems*, Random House 1978.) This guide to constructive therapy is used by many feminist therapists as a blueprint in their practices. It encourages the use of contracts between therapists and clients, with the clients evaluating whether the terms of the contract have been met by the end of the agreed-upon time period.

*State and Mind*, Women's Issue (vol. 4, no. 5). Anger; rape; women as healers; heterosexual politics; women and psychology; resource list. P.O. Box 89, Somerville, MA 02144, USA.

*Madness Network News*, Women's Issues (vol. 3, no. 6 and vol. 4 no. 3. P.O. Box 684, San Francisco, CA 94101, USA.



# commentary

# They've got us covered - maybe

by *Harry Beatty*

People who have a psychiatric label are often discriminated against when applying for insurance coverage, particularly disability insurance and life insurance. Insurers may simply refuse to issue them a policy at all, or may increase their premiums substantially, without ever proving that a greater-than-average risk is involved.

## Some employers will not hire people without

But the consequences of a refusal to insure may go beyond just denying a person coverage. Employers will sometimes not hire people with psychiatric labels simply because they do not qualify for a group disability or pension plan.

In an American study of this problem, done by The Centre for Public Representation, researchers examined the application forms and underwriting manuals of 18 insurance companies, sent out questionnaires to insurance agents, and looked at the available literature on mortality, health care usage, and relapse rates. They concluded that, while there was some evidence that persons with a psychiatric label were an increased risk, this did not justify the "extreme differential treatment in the availability of health and life insurance" given to them. Often coverage was not available, or only available at increased rates, without any real data to justify it.

Many people in Ontario with psychiatric labels can testify to experiences which would confirm this study. Insurance agents and insurance companies are wary of giving coverage to anyone who has had psychiatric treatment at any time, or even to anyone who has had a *relative* undergo psychiatric treatment. And as of December 1980, there is no legal recourse in Ontario for a person who is unjustly denied insurance coverage.

Some protection against discrimination in insurance will be extended to those with a psychiatric label in Ontario when the amended version of the Ontario *Human Rights Code*, which is currently before the Legislature, becomes law. These amendments will for the first time in Ontario protect people from discrimination because of handicap.

The definition of "handicap" includes not only those with a physical disability, but also those with "a condition of mental retardation or impairment", a learning disability, or a "mental disorder". Not only those who presently have these conditions will be protected from discrimination, but also those who have been so labelled in the past, as well as those simply *believed* to have these conditions. This will allow people who have been unjustly given psychiatric labels to pursue discrimination claims *without* admitting that the labels are accurate.

The protection of people against discrimination in insurance comes under a general provision prohibiting discrimination in all con-

tracts. However, there are provisions which make certain exceptions under which those with psychiatric labels may *not* have the right to equal treatment. Unequal treatment is permitted for a wide class of insurance policies if the distinctions are made on "*bona fide* and reasonable grounds". This does not make clear what kinds of discrimination will or won't be permitted. So, while a person unjustly denied coverage can bring a case before the Human Rights Commission (once this legislation is enacted), he or she does not really know what defences the insurer will bring forward.

Insurers should be required by law to provide data which will justify *any* discrimination they attempt to make in coverage or rates. They should be required to admit all employees to group plans of 25 or more participants, regardless of labelling. But if the private insurance industry is unwilling to adopt fair procedures which will make insurance available to *all* persons without bias, government operation of insurance plans may be the only alternative.

## Easy access to information is common

Another area of concern to people with psychiatric labels is the access to confidential medical information by insurers and its widespread distribution. Insurance companies collect medical information on applicants for coverage and on those who make claims. This information is collected from various sources, including the applicant or claimant, physicians, hospitals, clinics, employers, neighbours and schools. Once collected, the information may be shared widely, especially with other insurers.

In theory, medical information about you can only be collected with your consent. In practice this doesn't apply. During 1978 and 1979, at a Royal Commission of Inquiry into the Confidentiality of Health Records in Ontario, Commissioner Justice Horace Krever of the Supreme Court of Ontario heard widespread evidence of abuses concerning the collection of medical and psychiatric data on people.

*(NOTE: The Krever Commission Report will be examined in our next issue of* PHOENIX RISING.*)*

Insurance investigators have developed a variety of techniques for collecting information without getting the person's consent. In many cases a simple telephone call was successful. Especially outside the setting of the doctor's office or hospital, people tend to answer questions from anyone they think is in a position of authority. One investigation company had its staff pretend to be employees of a physician who was entirely fictional. Their inquiries to doctors and hospitals on behalf of the "doctor" were answered without question in the majority of cases. Often the information was used against the person in settling accident cases.



Even when your insurance company asks for your consent, you do not have much real protection. Since you do not usually know what is in your medical record at a hospital, or what your doctor will report to the insurance company, how will you know what you are consenting to? The medical profession, which strongly opposes letting people see their own medical records, *especially* psychiatric records, does not seem to have the same qualms about giving medical diagnoses and information to the medically untrained staff of insurance companies.

Consent forms used by insurers are so broad in most cases that they can get and distribute almost any kind of information about you, including your psychiatric history. An example presented by the Ontario Hospital Association in its brief to the Krever Commission showed the following release form:

> *I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health or my insurability, to give to _____ Insurance Company any such information. A photographic copy of this authorization shall be as valid as the original.*

Once you sign this, the insurance company could at any time in the future simply photocopy it and send it to anyone who had psychiatric information about you. At the present time there is no law in Ontario which prevents an insurer from demanding your signature on this kind of "blanket consent" as a condition of issuing you a policy. This type of invasion of privacy is especially harmful to people with a psychiatric label, since an inquiry by an insurer about a history of psychiatric treatment can have disastrous consequences to

the individual, especially since employers, friends or family members who may not be aware of the history may be asked questions.

People who have been in a psychiatric institution under *The Mental Health Act* face a special problem. Under the *Act*, there is a specific form, Form 14, which must be used before any disclosure, transmittal or examination of a clinical record is carried out. This consent to the release of information must be signed by the "patient", but it is to be signed by the nearest relative if the "patient" is considered not mentally competent or has not reached 18. So the Form 14 may be used for the release of information without the person's consent.

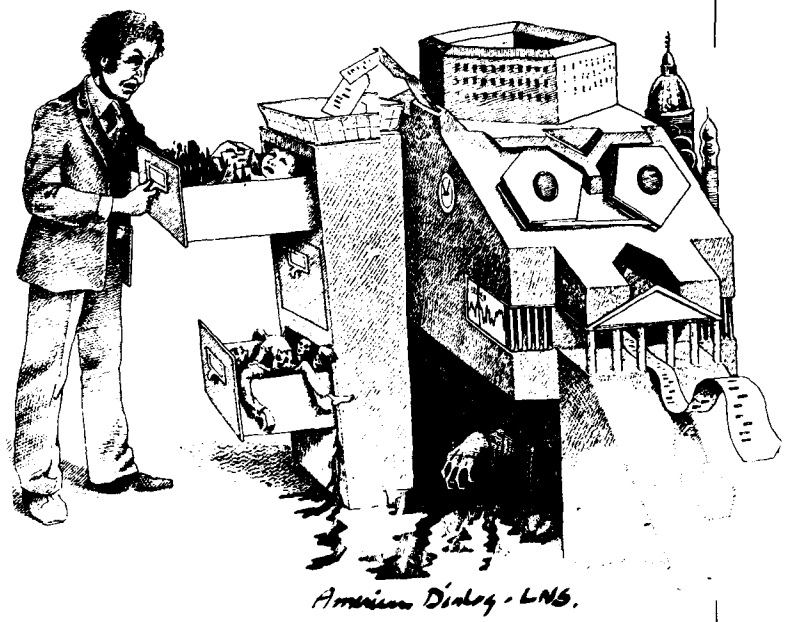
Also, many hospitals have psychiatric wards which are covered by *The Mental Health Act*. If an insurer or other third party requests information using an ordinary consent form from a public hospital with respect to someone who has been in a psychiatric ward, the hospital must refuse and require a Form 14. The very request for a Form 14, however, reveals that the person has had psychiatric treatment.

Once an insurance company has medical information in its files, there is little legally requiring it to remain confidential. Doctors and health professionals, as well as hospitals, are required to keep records confidential, but the laws which require this confidentiality do not extend to other people and organizations which may be in possession of medical information, including psychiatric histories.

The same consent form quoted from above also includes:

> *We may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.*

As well, it informs the applicant that information concerning him or her will be sent to the Medical Information Bureau. In fact, once consent is given, information is shared among insurers on a regular basis, through individual inquiries and through a large data bank, the




Medical Information Bureau.

Approximately 700 American and Canadian insurance companies use the Medical Information Bureau, a computer data bank located in the US. What it contains are certain "codes" rather than files on individuals. The question it raises, however, is how the privacy of individuals can be protected when health information is being sent out of the country. Regardless of the recommendations of the Krever Commission in this area, the problem will remain until some international agreement is reached concerning data banks.

# tongue in cheek

# Murphy's Law (applied to psychiatry)

by *Leonard Frank*

*(Reprinted from On The Edge, vol. 1, no. 6, November 1980.*

In recent years the discovery and wide-spread dissemination of Murphy's Law

("If anything can go wrong, it will") has inspired an enormous body of laws, rules, principles, and observations, etc., about the whys, ways, and wherefores of our society. The following ones deal exclusively


with psychiatry from the psychiatric inmates's perspective.....

In a psychiatric institution, whatever is good will become bad and whatever is bad will become worse.

The staff person a psychiatric inmate relates to best is always the first one to quit, get fired, or be transferred to another ward.

"Voluntary" psychiatric inmates retain their right to leave an institution only so long as they do not try to exercise that right.

The length of time people are incarcerated in a psychiatric institution varies directly with their resistance to being there.

The two easiest ways to get released from a psychiatric institution are to convince some psychiatrist that you want to stay there or have your insurance run out.

Psychiatrists reserve the worst "diagnoses" for those they like least and those who most threaten their authority. The worse the diagnosis, the more damaging the "treatment" ordered.

A psychiatrist's integrity varies inversely with the esteem in which he is held by his colleagues.

Mystification is the psychiatrist's first defense against the danger of being found out.

Psychiatrists will act reasonably only when all other possibilities have been exhausted.

When a psychiatrist has the right answer to a question, it may be assumed that he had misunderstood the question.

The greater the consensus among psychiatrists, the more likely they are to be wrong.

The size of a psychiatrist's ego is in direct proportion to the cost of his services and in inverse proportion to their value.

Psychiatric services expand to accommodate available funding.

One is never too late for an appointment with a psychiatrist.

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# Letters continued

appear to me that there *are* doctors who are far too "quick on the trigger" when ordering ECT, and it is the professional duty of those on staff of any institution who are concerned about the indiscriminate use of ECT to lay charges against their fellows. I wonder if ECT treatment should not be part of the undergraduate training of nurses, ward attendants, psychiatrists, psychologists and hospital administrators as a compulsory part of their training, and the same should apply to the use of medication, *especially in institutions*.

I suggest *The Mental Health Act* have new sections added to it that clearly spell out in detail both ECT treatment and the use of antipsychotic medication, especially in institutions, as there is right now a frightening pattern of overmedication going on that anyone, even a layman such as myself with a Grade Eight education, is distressed with, and that serves no real therapeutic purpose whatever for many patients.

I feel that you owe Dr. Littman a personal apology. I don't know if you have met with him personally or not, but if you have not you have done him and the Clarke a grave disservice.

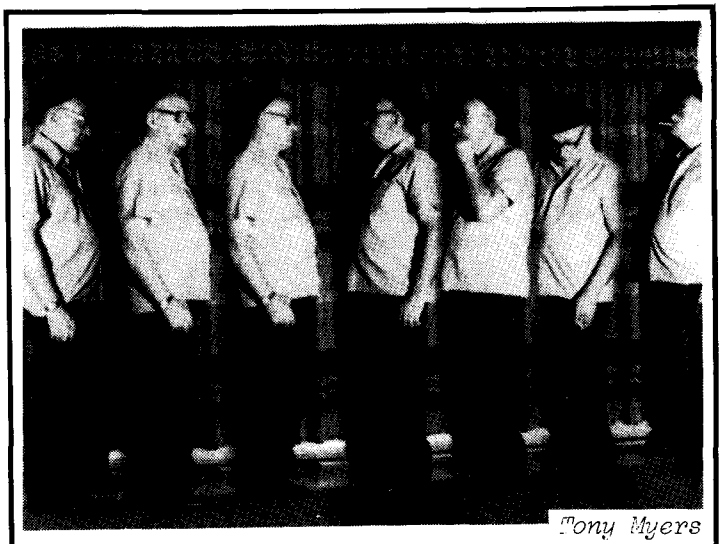
I have had to deal with a great number of health care professionals and educators who really had no business in their respective positions, so I really can say in this particular case of Dr. S. K. Littman, M.D., D.Psych., you are in effect causing personal hurt to a caring physician and a remarkable human being.

*--Don Tickle, Collingwood, Ontario*

*We can't quite see, Mr. Tickle, what you want us to apologize to Dr. Littman for. The only thing we have said about him is that he gives, or has given, shock treatments. If Dr. Littman believes in the use of shock, we have not insulted him in any way. If he does not, then presumably he would not be using it.*

*Any doctor whose name appears on our list who wishes it removed can have it removed*

*upon demonstrating to our satisfaction that either (1) the name was included by mistake, or (2) he or she no longer administers shock.*



Tony Myers

*"Listen Bub, the line-up to get out of this place starts back here."*

I must congratulate you all on the latest edition of PHOENIX RISING. I have read it from cover to cover carefully and reread it word for word to my handicapped friend.

I am saddened to read of the death of the young man Aldo Alviani. The loss of any life under these circumstances is tragic, but to be subjected to such drug therapy and be unable to fend for yourself is outrageous. We all fear being in such a position as to not be able to make our own decisions, and what others will do if we cannot look out for our own needs.

# *"My own sister had 25 prescriptions from different doctors..."*

The medical situation today for the mentally ill and others does not inspire one with confidence and the feeling one will receive the care one needs.

The abuse of drugs and the casual way doctors administer these potent drugs is unbelievable. I believe that the *à la carte* type of medicine that is practised is a large contributing factor, along with the fact that doctors get paid $4.15 for each prescription written. They charge individually for each thing they do. They write more and more prescriptions, and rely on this to our detriment. We are not told how to take the medication, or with what, or when, to say nothing of the side effects. Doctors do not take a blood sample to determine alcohol content prior to administering these potent medications. My own sister is an alcoholic and a drug addict, and at one time had 25 prescriptions from different doctors. It would not have taken much for a blind person to determine that she had been drinking. The ease with which they prescribe medication is often more for their convenience and the money than for the patient's best interest.

Queen Street is the pits. I visited there once with a social worker, and he commented that one would need to be assured of their passport out when visiting. To be confined is the final straw for many desperate people like Aldo Alviani. I have had a growing wonder if anyone medically has given any thought to administering caring and understanding, and really listening to the problems we face "outside" in the community. Most of us have been put down to a point where it destroys our confidence in ourselves, not to mention our sense of self worth. Most of us have been deprived of one of the basic rights all people consider precious, and that is "the right to be ourselves", and with this the right to make our own decisions, right or wrong. The right to make a mistake and have it accepted as a normal part of growing emotionally. Instead we are deprived of our dignity, self-respect and all our rights as human beings. Inhuman and unreasonable indignities are inflicted upon us when we can least fend for these rights. How we can ever conquer our emotional problems under these terms is beyond me. We are demeaned and degraded.

It is increasingly apparent that doctors are assessing all our problems as "in our head". The medical care suffers, and the tragic death of that young boy in Sick Children's Hospital is a case in point. Records there were also destroyed, and the child left to die without one doctor examining him. He too is a psychiatric statistic. It must end.

I have not been involved with drugs to a point of dependence, but the doctors got my sister hooked on barbiturates. I have had battles over laxatives, and was hooked on these and totally dependent. I managed this with the aid of my doctor. I finally got off them and learned to solve my problems through proper foods. Yet I still have a battle if I am hospitalized because there they load you with laxatives rather than give you the right food and drinks.

I have three medications, and I am not too confident I need them. I am on 80 grains of aspirin daily. The other medication for my

nerves I have chucked because I will not take anything that does not have a name I understand and explicit instructions. I have a high degree of allergies. Ten years ago I threw out eight medications and have not resumed any of them. I am none the worse, so why I needed them in the first place is a good question.

I mention this because it is not only in Queen Street that abuse of drugs occurs. Both my friend and I have noted that the doctors we have seen have no record of drugs taken that they can find easily without thumbing through pages of notes. They would not remember if I drank or not. There need to be some rules that order doctors to keep records that are readily available to any presiding physician regarding drugs. Patients must be given all information necessary to avoid difficulties. No doctor should prescribe drugs to make money or because it is easier than taking time to listen.

Our old family physician knew his patients and relied on the many aids that we had in the home instead of on potent drugs. He did listen. Today we are a statistic, and many doctors would not know us if they didn't have the file under their nose. I once read a doctor's file when he left it in the office with me, and you would not believe the sarcasm and utter rot he had written. There was nothing constructive about something as important as drugs.

As to the shock therapy, yes, it was a shocker, but nothing I was unaware of. My sister underwent massive shock therapy, and she lost much of her memory and it did not improve her. Then they forged ahead and did a lobotomy. Hers was as successful as any, and most do not leave the individual better off. I was under psychiatric care some years ago, and the doctor said, "My dear, how about a little shock?" Such audacity and stupidity. I doubt there is such a thing as "a little shock", and the "my dear" turned me off. I now realize since reading PHOENIX RISING that I had more sense than I gave myself credit for at the time. No amount of talk could convince me to subject myself to such a torture. Perhaps "a little shock" should be applied to the doctors.

***"They forged ahead and did a lobotomy..."***

PUBLIC SEMINARS ON ISSUES OF CONCERN TO THE HANDICAPPED

BOOST (Blind Organization of Ontario with Selfhelp Tactics) is sponsoring a series of public seminars, with the goal of educating handicapped people and the general public on relevant issues in the lives of handicapped people. All seminars will take place at the Rotary-Laughlen Centre, 110 Edward Street, Toronto, a building which is totally accessible. Many of the topics will be of great value to psychiatric inmates and ex-inmates, and all those interested are urged to attend. All seminars are on Thursdays at 6:30 p.m.

For further information, contact BOOST at (416)-364-4639, or write to BOOST at 100 Richmond St. E., Suite 408, Toronto, Ontario M5C 2P9.

February 12: Introduction to BOOST. Mike Yale (BOOST co-founder); Jo-Anne Yale (BOOST President); John Rae (BOOST Past President).

February 26: Legal Rights of Handicapped People. David Baker (Executive Director, Advocacy Resource Centre for the Handicapped); Yvonne Peters (Human Rights Commission of Saskatchewan).

March 26: Taxation and Aid Laws. Harry Beatty (Ontario Association for the Mentally Retarded); Patti Fuhrman (Community Legal Worker, ARCH); Jim Nicol (Financial Consultant, CNIB).

April 23: Assertiveness and Confidence-Building. Jo-Anne Yale (BOOST President); Jan Santos (Co-ordinator, Blind Services, Center for Independent Living, Berkeley, California); Anne Musgrave (Employment Consultant, Ontario Ministry of Labour).

May 21: Tactics for Community Organization. Mike Yale (BOOST co-founder); Angelo Nikias (former community organizer of the blind in Greece); Al Simpson (President of the Coalition of Provincial Organizations of the Handicapped); veteran Ontario community organizer (to be announced).

June 25: Human Rights Legislation. John Rae (Employment Consultant, Ontario Ministry of Labour, and BOOST Past President); Harry Monk (Canadian Human Rights Commission); representative of the Ontario Human Rights Commission (to be announced).

Time will be provided at each seminar for questions and discussion. Coffee will be served.

I was particularly interested in reading "My Psychotherapy" by Delana Munroe. I would wonder with such answers how she made it at all. It is close to home. One wonders who was sick, Delana or the doctor. I could add a few. Add "My dear, how about a little shock?" One doctor told me I was "a sick pervert", and he said I was the worst he ever saw in his entire practice. His track record left him in no position to point at me. He propositioned me and then said I was sick because I refused. *He told me* I was lesbian. I told him he needed more medical training and never saw him again. We could write a book on this subject.

All the best in going ahead.

*--Barbara Brown, Peterborough, Ontario*

★ ★ ★ ★ ★

In reply to the letter from David S. Heath published in the Fall 1980 issue of PHOENIX RISING, it is interesting that Dr. Heath seems not to recognize the potential ability that Ted, the young man whose experiences with electroconvulsive "therapy" were described in the December 8, 1979 issue of *Weekend*, had. With an IQ of 162, one must consider the possibility that he was bored in school with the work given to him, perhaps even with his companions. He hardly needs to be demeaned by being called an "unfortunate fellow" who "may have been treated unkindly".

If you are not depressed before ECT (and sometimes the initial depression can be caused simply by loneliness), you will probably be depressed when you realize what has been done to your brain. You may become even lonelier because most "normal" people cannot possibly understand what you are experiencing.

It takes five times the effort to achieve what was easy before, and even then achievement is not always possible. Many "normal" people will laugh at your mistakes in doing what comes easily and naturally to them, or at your forgetfulness.

The burden of being queer or mixed-up is one which you must carry with you until you die. There is no way to reverse brain damage. Brain damage incurred in a car accident is unfortunate, but does not carry the stigma of so-called "mental illness". Brain damage induced by electroconvulsive "therapy" is cruel and, I would suggest, unethical.

Why does a doctor have the right to administer partial euthanasia? It has been brought to my attention that at least one administrator of a psychiatric institution believes that while doctors are usually assumed to need more intelligence, most people can get along with less!

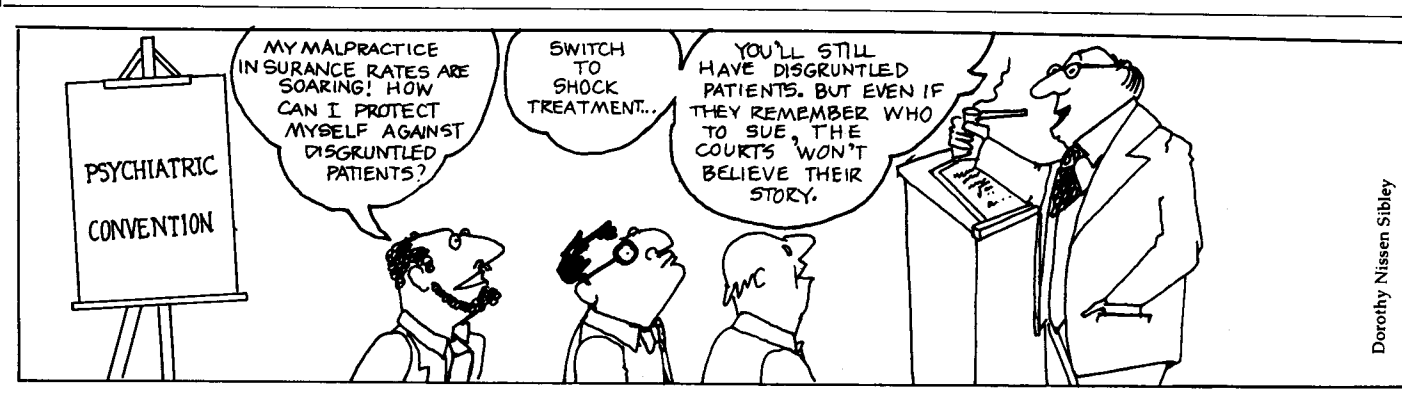
What has been forgotten about the past is often unimportant, and the loss can be lived with. The difficulty of advancing one's knowledge and abilities in a world which becomes ever more complex, and in which new skills are necessary even to keep pace in this fast-moving world, constitutes the cause of the frustration and the tragedy. We are even falling farther behind.

"Scrambled" is a very good way to describe one's confusion in the attempt to commit facts to memory. Hours of work of reinforcing material to be learned may result in only a small fraction of it being retained, and the ability to recall it at a later time may be even more minimal.

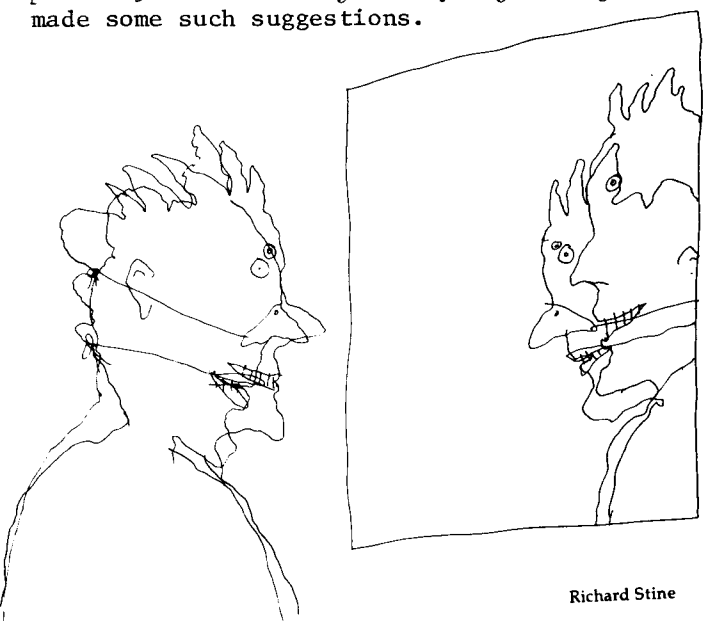
Because, and I quote, "the only treatment that a doctor can use for severe depression apart from ECT is antidepressant drugs", it may be that *doctors* should not be treating depression, since they are medical people whose abilities lie more in the area of science. I would forward the opinion that the cure for depression, except in the small percentage of cases where depression can be caused by a physical problem such as a brain lesion, may be in the area of practical prob-

*DONATIONS NEEDED!*

*THE MAD MARKET and our flea market stall are always in need on donations of used goods; proceeds from the sale of these goods help support ON OUR OWN. If you have anything you want to donate, call us and we'll pick it up anywhere in Metro. The number is 363-9807.*



lem solving, rather than in medical diagnosis of illness. It is my understanding that Thomas Stephen Szasz, M.D., Professor of Psychiatry at the State University of New York Upstate Medical Centre in Syracuse, and author of many books on the subject including *Schizophrenia, The Sacred Symbol of Psychiatry*, has made some such suggestions.



Richard Stine

With respect to shock therapy given on one side of the head only, impairment in the motor side of the brain can lead to decreased eye-hand co-ordination, while impairment in another area would noticeably affect speech. Brain damage is still brain damage, and its effects must be fought by tedious perpetual mental or physical exercise even to maintain a *status quo* of ability.

Many people who commit suicide may be depressed because there are too many unsolvable problems--among them brain damage--and it has become impossible for them to lead anything resembling a normal life. Dr. Heath thinks that suicides are not decreasing because people with depression are not coming forward for treatment. I dispute this opinion. There are people who have learned that the "cure" is worse than the "illness".

Perhaps ECT "encourages" people who for some reason are out of touch with a certain particular reality to become less "troublesome". But why is it possible for the medical profession to authorize permanent brain damage?

*--Catherine Furtenbacher, Hamilton, Ontario*

# "Brain damage is brain damage"

I recently finished reading the issue of PHOENIX RISING that dealt with shock treatments and their effects. As a Secretary to a Mental Health Program in New York (newly employed in this field) I found the article most informative and since these treatments are sometimes used in this program I passed PHOENIX RISING around the various departments. It probably won't bring about changes in the program ... but it certainly was "food for thought".

Congratulations on a most comprehensive and informative publication. Keep up the good work.

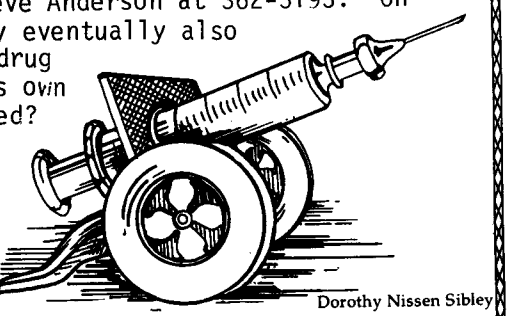
*--Mickey Delio, Staten Island, New York*

HELP NEEDED!

The computer belonging to the Association for the Preservation of Anti-Psychiatric Artifacts (APAPA) has broken down, and they desperately need funds to fix it. Send contributions to: APAPA Repair Fund, Box 9, Bayside, NY 11361, USA.

★ Congratulations to our printers Edith and Olino Capacchione on the birth of their son, Cedric (7 pounds, 10 ounces) born Nov. 10, 1980. ★

People interested in taking part in a drug rap group at the On Our Own drop-in should contact Steve Anderson at 362-3193. On Our Own may eventually also put out a drug book of its own - interested? Talk to Steve.



Dorothy Nissen Sibley

ANTIPSYCHIATRY DIRECTORY UPDATE

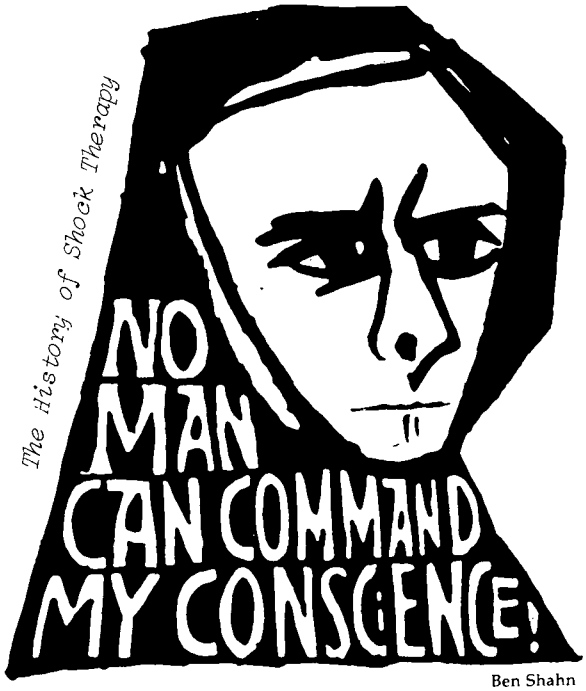
There has been a change in the address of the Lake Worth Mental Patients' Rights Association. The new address is:
*MENTAL PATIENTS' RIGHTS ASSOCIATION*, 811½ Lake Ave., Lake Worth, FL 33460.

Please keep us posted about additions, deletions or changes to the addresses of antipsychiatry groups so we can keep our Directory current. The entire Antipsychiatry Directory will be reprinted in the next issue of PHOENIX RISING. Changes should be sent to: Antipsychiatry Directory, PHOENIX RISING, Box 7251, Station A, Toronto, Ontario M5W 1X9.

I have personally been on Lithium for five years. I've had bouts with depression, and at other times too much energy, and have been psychotic also. It seems to me that Lithium (a mineral salt) through my body makes me feel moderately even, although it is not the only ingredient in my well-being.

I'm now working steadily and paying rent, buying a car, and have varied interests. To what extent Lithium helps in stability I'm not sure. I feel fine and hope to discontinue Lithium under doctor's recommendations. I feel Lithium is one of the most moderate medications in use, although there are occasional discomforts.

Lithium sometimes breaks down foods rapidly, resulting in fast bowel movements at surprising times. Your consumption of water probably increases in correlation with the perspiration you experience while taking this drug. Also anxiety, shaking, and trembling hands and body are sometimes doubled by Lithium, but I feel confidence modifies shaking.




Ben Shahn

I feel very strongly that my recovery depended on gradual self-confidence improvement, which came about by doing a lot of very small things like personal hygiene, determination, punctuality, and being reliable. It took time and was frustrating, but also rewarding, in that when I accomplished something, no matter how small, I felt good.

The important thing to me is that I'm now doing more and receiving more because I've got spirit, desire, love, hope, and continuing faith in God. This is quite a change from avoidance of responsibility, withdrawal, and not much desire because of depression.

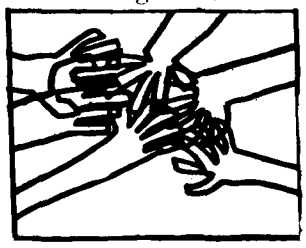
*--S. Peter, Toronto, Ontario*

The Shock Issue of PHOENIX RISING arrived early this week (including the extra copies I ordered), and it looks and reads great. I'm sure there will be many opportunities to put it to good use in our struggle against "electrotherapy", which is the term the electroshock specialists prefer to use nowadays. Congratulations to you and the PR staff for a truly fine job.

# *A plane-load of 88 people came over from Italy*

Things are going well here. Our conference and public forums last month were successful. A plane-load of 88 people cane over from Italy. Virtually all the participants from Europe were mental health workers and professionals. With few exceptions the American participants were former psychiatric inmates. This was a problem, and highlighted a major difference between the US/Canadian and European movements. One of the important benefits of the conference was the fact that, in spite of these background differences, everyone got along well with one another and strong ties of friendship developed for many of us.

Keep up the good work. I'm so glad to have all the extra copies of the Shock Issue. Already, without any push from me, two copies have been sold at the BACAP (bay Area Committee for Alternatives to Psychiatry) office. Incidentally, a BACAP volunteer liked the article on Friends and Advocates and is talking about starting a similar group in San Francisco. I'll let you know if this materializes.




More than ever I feel our day is coming soon--and we're gonna win! In struggle and brotherhood.

*--Leonard Frank, San Francisco, California*

COMING SOON IN PHOENIX RISING!

--The Krever Commission on confidentiality of health records: findings and recommendations.
--Children and psychiatry.
--The International Year of Disabled Persons: what will it mean to psychiatric inmates and ex-inmates?
--News, views, humour, poetry.
--Much, much more!

# CLASSIFIEDS

We invite the public and members of ON OUR OWN to submit ads for this section. Rates are $2.50 for each 25 words or less. Members of ON OUR OWN may advertise FREE up to 25 words. Cash, cheque or money order must be received before advertisements are published. Mail your ad with payment to: Classified, [illegible], Box 7251, Station A, Toronto, Ontario M5W 1X9.

## PUBLICATIONS

BULLDOZER. "The Only Effective Vehicle for Prison Reform."
Prisoners Solidarity Collective, a self-help group of ex-prisoners and supporters, has just published a newsletter with the above title. The contents are all (except the editorial) written by prisoners fighting the state's use of Special Handling Units, skin frisks, involuntary transfers, and other efforts to control prisoners and disrupt organizing activities. Letters, comments and donations welcome. Write for a copy c/o Prisoners Solidarity Collective, P.O. Box 2, Station O, Toronto, Ont. M4B 2B0. $1. Free to prisoners, including psychiatric prisoners.

## FRIENDS

Young man, 36, 5'3", seeking matrimony. Age no barrier. Photo & phone number a must. Janos Krakoczi, 42 Bellview Ave., Toronto.

BACAP (Bay Area Committee for Alternatives to Psychiatry) has started an On Our Own Pen Pal Club. They will be distributing the names of those interested in joining to all psychiatric inmate liberation movement publications (including [illegible]). Those interested in joining should write to: On Our Own Pen Pal Club, c/o BACAP, 944 Market St., Rm. 701, San Francisco, CA 94102, USA. Include your name, address, postal code, and interests in 10 words or less.

## WORK WANTED

Do you need...
CUPBOARDS BUILT?
SHELVING INSTALLED?
MINOR RENOVATIONS & REPAIRS?
Leave message for Len Lorimer at The Mad Market, 363-9807.

## SPACE NEEDED

ON OUR OWN immediately needs space (1500-2000 sq. ft.) for drop-in and offices. Queen-Bathurst area. 362-3193.

## VOLUNTEERS NEEDED

WRITERS needed for [illegible] and for ON OUR OWN's newsletter, THE MAD GRAPEVINE. Also people to help with typing, assembling, mailing. Call Cathy ([illegible]) or Don (TMG) at 362-3193.

## PEN PALS

The ON OUR OWN PEN PAL CLUB is off the ground. (See *Classified* section of this issue for how to get your name included.)

We're happy to print the first list of inmates and ex-inmates who would like to hear from YOU.

Mary Eileen McCally Bergesch, 23100 Cohasset St., Canoga Park, CA 91304
Don H. Culwell, 2502 Waterford, San Antonio, TX 78217
Donna Ellis, Route 1, Box 159-Z, Spicewood, TX 78669
Barbara J. Gray, 138 S. Willard St., Burlington, VT 05401
Alicia Hartford, 362 Elm St., New Haven, CT 06511
Gloria E. Huguelet, 770 W. Market St., York, PA 17404
John Jones, 1139 Market (No. 241), San Francisco, CA 94103
Clyde Leonard Kondracik, Box C, Apt. 20, Waupun WI 53963
Jane L. Kysor, 3743 Garden St., Santa Cruz, CA 95062
Frank Lugo, Box 1000, Chattahoochee, FL 32324
Bill McCormick, Innisfree Village, Route 2, Box 506, Crozet, VA 22932
Harold R. McGinnis, Countvail, Eureka, CA 95501
Rex Milton, 102-672 College Dr. S.E., Medicine Hat, Alta T1A 7R5
Alan Mountain, 40 Howard St., Presque Isle, ME 04769
Esther Polonsky, 101 Summit Lane (Apt. F-2), Bala Cynwyd, PA 19004
Paul Polston, Drawer A, Atascadero, CA 93422
Gregg Russell, 40 East 4th St., Emporium, PA 15834
Sharon Cotter Sasso, 23-39 Corporal Kennedy St. Bayside, NY 11360
Lew Scholl, 2802 S.E. 67th (No. 7), Portland, OR 97206
Lynne Sharpe, 5667 Thornhill Dr., Oakland, CA 94611
Harry Steinman, SMU General Delivery, New York, NY 10001
Gerald A. Willey, 1020½ North St., Caldwell, OH 43724
Mel Wilson, Box 1882, Paso Robles, CA 93446
Frances Wolfe, 294 Delaware Ave. (Apt. 1), Albany, NY 12209
Bob Woods, c/o ALMP, 1427 Walnut St., Philadelphia, PA 19109

# METROPOLITAN TORONTO EMERGENCY RESOURCES LIST

## Emergency Accommodation: Men

*FRED VICTOR MISSION*, 147 Queen St. E., 364-8228. Names taken at 4 p.m. for 6 p.m. checkin. Out by 8 (9 on Sunday). $2 if you can pay.

*GOOD SHEPHERD REFUGE*, 412 Queen St. E., 869-3619. Checkin 7 p.m., out after 6 a.m. breakfast. Mon.-Fri. Free.

*SINGLE MEN'S SERVICES*, 319-335 George St., 367-8597. Open 4 p.m., out by 9 a.m. Dinner & breakfast, bag lunch if working. Free.

*CITY SHELTER*, 349 George St., 960-9240. Checkin 4-12 p.m., out by 10 a.m. No free meals. $2.50/night.

*SALVATION ARMY HOSTEL*, 135 Sherbourne St., 366 2733. Checkin 9:30 a.m.-3:30 p.m., out by 8 a.m. 3 meals/day. $2 if you can pay.

## Emergency Accommodation: Women

*ANDUHYAUN*, 106 Spadina Rd., 920-1492. Native women. 24-hr. admission. 12:00 curfew. Meals. $40/wk. if you can pay.

*INTERVAL HOUSE*, 596 Huron St., 924-1491. Priority battered women (& children). 24-hr. admission. Free.

*NELLIES*, 275A Broadview Ave., 461-1084. 24-hr. admission Mon.-Fri., weekends after 4 p.m. if possible. 2-week maximum stay. Free--donations if possible.

*STOP 86*, 86 Madison Ave., 922-3271. Women 16-25. Free--donations if possible.

*STREETHAVEN*, 87 Pembroke St., 967-6060. 24-hr. admission. Light lunch, dinner. 2-week maximum stay. Free.

*TORONTO COMMUNITY HOSTEL*, 191 Spadina Rd., 925-4431. Checkin by midnight, out by 9 a.m. Meals. Maximum stay 5 days (extension possible). Free--donations if possible.

*WOMEN IN TRANSITION*, 143 Spadina Rd., 967-5227. Women with children. 24-hr. admission--phone first. Meals. 1-6 week stay. Free.

*EVANGELINE RESIDENCE*, 2809 Dundas St. W., 762-9636. 24-hr. admission. Meals. $40/wk. if you can pay.

*WOODLAWN RESIDENCE*, 80 Woodlawn Ave. E., 923-8454. Checkin after 1, out by 12. Emergency beds free. Meals.

## Emergency Accommodation: Families

*FAMILY RESIDENCE*, 674 Dundas St. W., 363-5227. 24-hr. admission--phone first. Short-term. Usually free.

## Detox Centres

*ARF DETOX*, 410 Dundas St. W., 363-4300. Men & women. 24-hr. admission.

*KNOX AVE./TORONTO EAST GENERAL DETOX*, 109 Knox Ave., 461-7408. Men. 24-hr. admission.

*ST. MICHAEL'S HOSPITAL DETOX*, 314 Adelaide St. E., 360-6640. Men. 24-hr. admission.

*TORONTO WESTERN HOSPITAL DETOX*, 16 Ossington Ave., 533-7945. Men. 24-hr. admission.

## Emergency Welfare

*EMERGENCY SERVICES*, 325 George St., 367-8600. After hours.

## Crisis Counselling

*DISTRESS CENTRE 1* (24 hours), 598-1121.

*DISTRESS CENTRE 2* (24 hours), 486-1456.

*TORONTO EAST GENERAL CRISIS INTERVENTION UNIT*. Weekdays 9-5, 461-0311. Weekends, after hours, 461-8272, Ext. 220.

*SALVATION ARMY EMERGENCY COUNSELLING AND SUICIDE PREVENTION BUREAU* (24 hours), 368-3111.

*TEEN CHALLENGE* (24 hours), 463-4900.

*YOUTHLINE*. Sun.-Thurs. 4:30-1:00, Fri.-Sat. 4:30-3:00. 922-1700.

*RAPE CRISIS CENTRE* (24 hours), 964-8080.

*PARENTS ANONYMOUS* (24 hours), 967-7227. (For abusing parents.)

*ADDICTION RESEARCH FOUNDATION* (24 hours), 595-6128. (Drugs, alcohol.)

*STREET HAVEN AT THE CROSSROADS* (24 hours), 967-6060. (Women--drugs, alcohol.)

*METROPOLITAN COMMUNITY CHURCH*. Mon.-Thurs. 7:00-10:30. 977-9835. (Gays.)

*TORONTO AREA GAYS*. Mon.-Thurs. 7:00-10:30. 964-6600.

*Because of the shortage of crisis services in Toronto, these lines are often busy. If you need help and cannot get through right away, please keep trying.*

For non-emergency information about welfare, accommodation, etc., you can call the Community Information Centre of Metropolitan Toronto at 863-0505 during business hours.